HOUSE BILL NO. 119

INTRODUCED BY C. HUNTER

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATED TO EMPLOYMENT; AUTHORIZING NEGOTIATION OF AGREEMENTS WITH TRIBAL GOVERNMENTS TO RECOGNIZE AND GIVE EFFECT TO CERTAIN TRIBAL WORKERS' COMPENSATION PLANS; AUTHORIZING PLAN NO. 1 EMPLOYERS TO TRANSFER CLAIM LIABILITIES TO THIRD PARTIES; REQUIRING CONTROLLING PERSONS OF PROFESSIONAL EMPLOYER ORGANIZATIONS TO SUBMIT FINGERPRINTS; INCLUDING RELIGIOUS ORGANIZATIONS AS EMPLOYERS FOR WORKERS' COMPENSATION PURPOSES UNDER CERTAIN CONDITIONS; PROVIDING A RANGE OF UP TO 3 PERCENT ON CERTAIN ASSESSMENTS ON PAID LOSSES; REVISING THE DEFINITION OF "UNINSURED EMPLOYER"; PROVIDING FOR CERTAIN VOLUNTARY NONBINDING MEDIATION; SPECIFYING TYPES OF MEDICAL FEE SCHEDULES THAT MAY BE USED FOR WORKERS' COMPENSATION CLAIMS; PROVIDING TIMELINES FOR PAYMENTS AND INTEREST PENALTIES; REMOVING THE 26-WEEK LIMIT ON TEMPORARY PARTIAL DISABILITY BENEFITS; ALLOWING FOR INCREASED PRESCRIPTION SUPPLIES; REVISING APPLICATION TIMELINES UNDER THE SUBSEQUENT INJURY FUND; INCREASING THE TRIGGERING AMOUNT NECESSARY FOR ASSESSMENTS UNDER THE SUBSEQUENT INJURY FUND; AMENDING SECTIONS 39-8-202, 39-71-107, 39-71-117, 39-71-118, 39-71-123, 39-71-201, 39-71-307, 39-71-501, 39-71-601, 39-71-613, 39-71-704, 39-71-711, 39-71-712, 39-71-727, 39-71-743, 39-71-905, 39-71-915, 39-71-2339, AND 39-73-104, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Tribal employment coverage.** The department may, as provided in Title 18, chapter 11, enter into an agreement with a tribal government to recognize and give effect to tribal workers' compensation plans or self-insured plans that the department determines provide adequate coverage to persons who are:

(1) employed by an enrolled tribal member or by an association, business, corporation, or other entity at least 51% of which is owned by one or more enrolled tribal members; and

(2) working outside the exterior boundaries of an Indian reservation.

NEW SECTION. **Section 2. Transfer of claim liabilities.** (1) A current or former self-insurer or group may transfer existing workers' compensation claim liabilities to another entity upon authorization from the department and concurrence of the Montana self-insurers guaranty fund by:

(a) submitting an application on a form designated by the department;

(b) completing an agreement of assumption and guarantee of workers' compensation liabilities;

(c) submitting a loss portfolio transfer agreement; and

(d) posting a security deposit.

(2) If the assuming entity fails to meet the terms of the transfer agreement, liability reverts to the original self-insurer.

(3) The entity assuming liability for a claim shall comply with all reporting requirements set by the department.

(4) The department shall adopt rules to implement this section.

Section 3. Section 39-8-202, MCA, is amended to read:

"39-8-202. Initial license application -- application fee -- standards -- provisional license. (1) An applicant for initial licensure as a professional employer organization or group shall file with the department a completed application on a form provided by the department.

(2) The application must be accompanied by a nonrefundable application fee and any material or information required by the department that demonstrates compliance with the requirements of this chapter. The application fee is:

(a) $750 for a resident or nonresident unrestricted license; and

(b) $500 for a restricted license.

(3) As a condition of licensure under this chapter, an applicant who is not a resident or who is domiciled outside the state must first be licensed as a professional employer organization or group in the state in which the applicant is a resident or is domiciled if licensing is required by that state.

(4) An applicant for licensure as a professional employer organization or group must meet one of the following applicable standards:

(a) An individual must be 18 years of age or older.

(b) A partnership or a limited partnership shall provide the names and home addresses of all partners, indicate whether each partner is a general or a limited partner, and include a copy of the partnership agreement or an affidavit signed by all partners acknowledging that a written partnership agreement does not exist.

(c) A corporation shall state the names and home addresses of all officers, directors, and shareholders who own a 5% or greater interest in the corporation. A domestic or foreign corporation must have filed any required documents with the secretary of state and shall remain in good standing to conduct business pursuant to this chapter.

(d) A limited liability company shall state the names and home addresses of those individuals who own a 5% or greater interest in the limited liability company. A domestic or foreign limited liability company must have filed any required documents with the secretary of state and shall remain in good standing to conduct business pursuant to this chapter.

(e) A group:

(i) must be authorized to act on behalf of the group;

(ii) shall include for each professional employer organization within the group the information required in subsection (4); and

(iii) shall guarantee, on a form provided by the department and executed by each professional employer organization within the group, payment of all financial obligations with respect to wages, payroll-related taxes, insurance premiums, and employee benefits of each other member within the group.

(5) (a) An applicant shall also provide:

(i) the trade name or names under which the applicant conducts business, the business's taxpayer or employer identification number, the address of the business's principal place of business in the state, and the addresses of any other offices within the state through which the applicant intends to conduct business as a professional employer organization or group. If the applicant's principal place of business is located in another state, the address must be provided.

(ii) a list by jurisdiction of each name under which the applicant has operated in the preceding 5 years, including any alternative names, names of predecessors, and names of related business entities with common majority ownership, and detailed information on the background of each controlling person to the extent required by the department; and

(iii) other information requested by the department to show that the applicant and each controlling person are of good moral character, have business integrity, and are financially responsible. "Good moral character" means a personal history of honesty, trustworthiness, and fairness; a good reputation for fair dealings; and respect for the rights of others and for the laws of this state and nation.

(b) (i) As a prerequisite to the issuance of a license, the department shall require the applicant and any controlling person to submit fingerprints for the purpose of fingerprint checks by the Montana department of

justice and the federal bureau of investigation.

(ii) The applicant and any controlling person shall sign a release of information to the department and ~~is~~ are responsible to the department of justice for the payment of all fees associated with the criminal background check.

(iii) Upon completion of the criminal background check, the department of justice shall forward all criminal justice information, as defined in 44-5-103, concerning the applicant or any controlling person that involves the conviction of a criminal offense in any jurisdiction to the department, as authorized in 44-5-303.

(iv) At the conclusion of any background check required by this section, the department must receive the criminal background check report but may not receive the fingerprint card of the applicant or of any controlling person. Upon receipt of the criminal background check report, the department of justice shall promptly destroy the fingerprint card of the applicant and of any controlling person.

(c) If an applicant or any controlling person has a history of criminal convictions, then pursuant to 37-1-203, the applicant or controlling person has the opportunity to demonstrate to the department that the applicant or controlling person is sufficiently rehabilitated to warrant the public trust, and if the department determines that the applicant or controlling person is not, the license may be denied.

(6) (a) Except for an applicant who is granted a restricted license under subsection (9), an applicant shall maintain a tangible accounting net worth of not less than $50,000, evidenced by:

(i) providing financial statements that have been independently audited by a certified public accountant in accordance with generally accepted accounting principles; or

(ii) providing independently compiled financial statements and a $100,000 security deposit in a form that is acceptable to the department.

(b) If, after licensure, an applicant defaults in paying wages or payroll-related taxes or in meeting any liability arising pursuant to Title 39, chapter 71, or this chapter, the security deposit may be used to meet those obligations. The security deposit may not be used in determining the net worth of an applicant.

(c) (i) Documents submitted to establish net worth must reflect net worth as of a date not more than 6 months prior to the date on which the application is submitted.

(ii) Financial statements submitted must be attested by the president, chief financial officer, and at least one controlling person of the professional employer organization or group.

(iii) If an applicant is unable to meet the $50,000 net worth requirement, the applicant shall provide to the department a surety bond, a letter of credit, or marketable securities acceptable to the department in an amount of not less than $50,000 to cover the deficiency. If, after licensure, an applicant defaults in paying wages or

payroll-related taxes or in meeting any liability arising pursuant to Title 39, chapter 71, or this chapter, the surety bond, letter of credit, or marketable securities provided to the department may be used to meet those obligations.

(7) The applicant shall maintain a positive working capital, as evidenced by financial statements.

(8) The department may provide by rule for the acceptance, in lieu of the requirements of subsections (6) and (7), of an affidavit provided by a bonded, independent, and qualified assurance organization that has been approved by the department certifying the qualifications of a professional employer organization or group seeking licensure under this chapter.

(9) The department may issue a restricted license for limited operation within this state to a professional employer organization or group that is a resident of or domiciled in another state if:

(a) the applicant's state of residence or domicile provides for licensing of professional employer organizations or groups and the applicant is licensed and in good standing in that state and that state grants a similar privilege for restricted licensing to professional employer organizations or groups that are residents of or domiciled in this state and that are licensed under this chapter;

(b) the applicant does not maintain an office, a sales force, or a sales representative in this state and does not solicit clients who are residents of or domiciled in this state; and

(c) the applicant does not have more than 100 leased employees working in this state.

(10) An applicant for a license shall appoint a recognized and approved entity as its registered agent to receive service of legal process issued against it in this state if a registered agent has not already been appointed.

(11) The department may issue a provisional license to an applicant that allows the applicant to operate in this state while the applicant's application is being processed by the department. The department may not charge a fee for a provisional license. The department may adopt rules to implement the provisions of this subsection.

(12) A license issued under 39-8-204 or this section may not be transferred."

Section 4. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims -- in-state claims examiners. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act must be examined by a claims examiner in Montana. For a claim to be considered as

examined by a claims examiner in Montana, the claims examiner examining the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an office located in Montana, and examine Montana claims from that office. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act at the Montana office of the claims examiner examining the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the claims examiner's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) (a) An insurer that uses a third-party agent to provide the insurer with claim examination services shall notify the department in writing of a change of a third-party agent at least 14 days in advance of the change.

(b) The department may assess a penalty not to exceed $200 against an insurer that does not comply with the advance notice provision in subsection (4)(a). The penalty may be assessed for each failure by an insurer to give the required advance notice.

(5) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits ~~requested by a claimant~~ are denied~~,~~ to a claimant, a written explanation of how the claimant may appeal an insurer's decision; and

(c) a written explanation of the amount of wage-loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(6) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(7) The department may adopt rules to implement this section.

(8) (a) For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 5. Section 39-71-117, MCA, is amended to read:

"39-71-117. Employer defined. (1) "Employer" means:

(a) the state and each county, city and county, city school district, and irrigation district; all other districts established by law; all public corporations and quasi-public corporations and public agencies; each person; each prime contractor; each firm, voluntary association, limited liability company, limited liability partnership, and private corporation, including any public service corporation and including an independent contractor who has a person in service under an appointment or contract of hire, expressed or implied, oral or written; and the legal representative of any deceased employer or the receiver or trustee of the deceased employer;

(b) any association, corporation, limited liability company, limited liability partnership, or organization that seeks permission and meets the requirements set by the department by rule for a group of individual employers to operate as self-insured under plan No. 1 of this chapter; ~~and~~

(c) any nonprofit association, limited liability company, limited liability partnership, or corporation or other entity funded in whole or in part by federal, state, or local government funds that places community service participants, as described in 39-71-118(1)(e), with nonprofit organizations or associations or federal, state, or local government entities; and

(d) a religious corporation, organization, or trust receiving remuneration for a project performed by its members on or off the property of the corporation, organization, or trust.

(2) A temporary service contractor is the employer of a temporary worker for premium and loss experience purposes.

(3) Except as provided in chapter 8 of this title, an employer defined in subsection (1) who uses the services of a worker furnished by another person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, is presumed to be the employer for workers' compensation premium and loss experience purposes for work performed by the worker. The presumption may be rebutted by substantial credible evidence of the following:

(a) the person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, furnishing the services of a worker to another retains control over all aspects of the work performed by the worker, both at the inception of employment and during all phases of the work; and

(b) the person, association, contractor, firm, limited liability company, limited liability partnership, or

corporation, other than a temporary service contractor, furnishing the services of a worker to another has obtained workers' compensation insurance for the worker in Montana both at the inception of employment and during all phases of the work performed.

(4) An interstate or intrastate common or contract motor carrier that maintains a place of business in this state and uses an employee or worker in this state is considered the employer of that employee, is liable for workers' compensation premiums, and is subject to loss experience rating in this state unless:

(a) the worker in this state is certified as an independent contractor as provided in 39-71-417; or

(b) the person, association, contractor, firm, limited liability company, limited liability partnership, or corporation furnishing employees or workers in this state to a motor carrier has obtained Montana workers' compensation insurance on the employees or workers in Montana both at the inception of employment and during all phases of the work performed."

Section 6. Section 39-71-118, MCA, is amended to read:

"39-71-118. Employee, worker, volunteer, and volunteer firefighter defined. (1) As used in this chapter, the term "employee" or "worker" means:

(a) each person in this state, including a contractor other than an independent contractor, who is in the service of an employer, as defined by 39-71-117, under any appointment or contract of hire, expressed or implied, oral or written. The terms include aliens and minors, whether lawfully or unlawfully employed, and all of the elected and appointed paid public officers and officers and members of boards of directors of quasi-public or private corporations, except those officers identified in 39-71-401(2), while rendering actual service for the corporations for pay. Casual employees, as defined by 39-71-116, are included as employees if they are not otherwise covered by workers' compensation and if an employer has elected to be bound by the provisions of the compensation law for these casual employments, as provided in 39-71-401(2). Household or domestic employment is excluded.

(b) any juvenile who is performing work under authorization of a district court judge in a delinquency prevention or rehabilitation program;

(c) a person who is receiving on-the-job vocational rehabilitation training or other on-the-job training under a state or federal vocational training program, whether or not under an appointment or contract of hire with an employer, as defined in 39-71-117, and, except as provided in subsection (9), whether or not receiving payment from a third party. However, this subsection (1)(c) does not apply to students enrolled in vocational training programs, as outlined in this subsection, while they are on the premises of a public school or community

college.

(d) an aircrew member or other person who is employed as a volunteer under 67-2-105;

(e) a person, other than a juvenile as described in subsection (1)(b), who is performing community service for a nonprofit organization or association or for a federal, state, or local government entity under a court order, or an order from a hearings officer as a result of a probation or parole violation, whether or not under appointment or contract of hire with an employer, as defined in 39-71-117, and whether or not receiving payment from a third party. For a person covered by the definition in this subsection (1)(e):

(i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an impairment award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part 4, for a full-time employee at the time of the injury; and

(ii) premiums must be paid by the employer, as defined in 39-71-117(3), and must be based upon the minimum wage established under Title 39, chapter 3, part 4, for the number of hours of community service required under the order from the court or hearings officer.

(f) an inmate working in a federally certified prison industries program authorized under 53-1-301;

(g) a volunteer firefighter as described in 7-33-4109 or a person who provides ambulance services under Title 7, chapter 34, part 1; ~~and~~

(h) a person placed at a public or private entity's worksite pursuant to 53-4-704. The person is considered an employee for workers' compensation purposes only. The department of public health and human services shall provide workers' compensation coverage for recipients of financial assistance, as defined in 53-4-201, or for participants in the food stamp program, as defined in 53-2-902, who are placed at public or private worksites through an endorsement to the department of public health and human services' workers' compensation policy naming the public or private worksite entities as named insureds under the policy. The endorsement may cover only the entity's public assistance participants and may be only for the duration of each participant's training while receiving financial assistance or while participating in the food stamp program under a written agreement between the department of public health and human services and each public or private entity. The department of public health and human services may not provide workers' compensation coverage for individuals who are covered for workers' compensation purposes by another state or federal employment training program. Premiums and benefits must be based upon the wage that a probationary employee is paid for work of a similar nature at the assigned worksite.

(i) a member of a religious corporation, organization, or trust while performing services for the corporation, organization, or trust, as described in 39-71-117(1)(d).

(2) The terms defined in subsection (1) do not include a person who is:

(a) participating in recreational activity and who at the time is relieved of and is not performing prescribed duties, regardless of whether the person is using, by discount or otherwise, a pass, ticket, permit, device, or other emolument of employment;

(b) performing voluntary service at a recreational facility and who receives no compensation for those services other than meals, lodging, or the use of the recreational facilities;

(c) performing services as a volunteer, except for a person who is otherwise entitled to coverage under the laws of this state. As used in this subsection (2)(c), "volunteer" means a person who performs services on behalf of an employer, as defined in 39-71-117, but who does not receive wages as defined in 39-71-123.

(d) serving as a foster parent, licensed as a foster care provider in accordance with 52-2-621, and providing care without wage compensation to no more than six foster children in the provider's own residence. The person may receive reimbursement for providing room and board, obtaining training, respite care, leisure and recreational activities, and providing for other needs and activities arising in the provision of in-home foster care.

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter any volunteer as defined in subsection (2)(c).

(4) (a) The term "volunteer firefighter" means a firefighter who is an enrolled and active member of a governmental fire agency organized under Title 7, chapter 33, except 7-33-4109.

(b) The term "volunteer hours" means all the time spent by a volunteer firefighter in the service of an employer, including but not limited to training time, response time, and time spent at the employer's premises.

(5) (a) If the employer is a partnership, limited liability partnership, sole proprietor, or a member-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any member of the partnership or limited liability partnership, the owner of the sole proprietorship, or any member of the limited liability company devoting full time to the partnership, limited liability partnership, proprietorship, or limited liability company business.

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the partners, sole proprietor, or members to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (5)(d). A partner, sole proprietor, or member is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $900 a month and not more than 1 1/2 times the state's average weekly wage.

(6) (a) If the employer is a quasi-public or a private corporation or a manager-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any corporate officer or manager exempted under 39-71-401(2).

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the corporate officer or manager to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (5)(d). A corporate officer or manager is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (6)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $200 a week and not more than 1 1/2 times the state's average weekly wage.

(7) (a) The trustees of a rural fire district, a county governing body providing rural fire protection, or the county commissioners or trustees for a fire service area may elect to include as an employee within the provisions of this chapter any volunteer firefighter. A volunteer firefighter who receives workers' compensation coverage under this section may not receive disability benefits under Title 19, chapter 17.

(b) In the event of an election, the employer shall report payroll for all volunteer firefighters for premium and weekly benefit purposes based on the number of volunteer hours of each firefighter times the average weekly wage divided by 40 hours, subject to a maximum of 1 1/2 times the state's average weekly wage.

(c) A self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer firefighter pursuant to subsection (7)(a) and when injured in the course and scope of employment as a volunteer firefighter, may in addition to the benefits described in subsection (7)(b) be eligible for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080 hours a year. The trustees of a rural fire district, a county governing body providing rural fire protection, or the county commissioners or trustees for a fire service area may make an election for benefits. If an election is made, payrolls must be reported and premiums must be assessed on the assumed wage.

(8) Except as provided in chapter 8 of this title, an employee or worker in this state whose services are furnished by a person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, to an employer, as defined in 39-71-117, is presumed to be under the control and employment of the employer. This presumption may be rebutted as provided in 39-71-117(3).

(9) A student currently enrolled in an elementary, secondary, or postsecondary educational institution who is participating in work-based learning activities and who is paid wages by the educational institution or business partner is the employee of the entity that pays the student's wages for all purposes under this chapter. A student who is not paid wages by the business partner or the educational institution is a volunteer and is subject to the provisions of this chapter.

(10) For purposes of this section, an "employee or worker in this state" means:

(a) a resident of Montana who is employed by an employer and whose employment duties are primarily carried out or controlled within this state;

(b) a nonresident of Montana whose principal employment duties are conducted within this state on a regular basis for an employer;

(c) a nonresident employee of an employer from another state engaged in the construction industry, as defined in 39-71-116, within this state; or

(d) a nonresident of Montana who does not meet the requirements of subsection (10)(b) and whose employer elects coverage with an insurer that allows an election for an employer whose:

(i) nonresident employees are hired in Montana;

(ii) nonresident employees' wages are paid in Montana;

(iii) nonresident employees are supervised in Montana; and

(iv) business records are maintained in Montana.

(11) An insurer may require coverage for all nonresident employees of a Montana employer who do not meet the requirements of subsection (10)(b) or (10)(d) as a condition of approving the election under subsection (10)(d)."

Section 7. Section 39-71-123, MCA, is amended to read:

"39-71-123. Wages defined. (1) "Wages" means all remuneration paid for services performed by an employee for an employer, or income provided for in subsection (1)(d). Wages include the cash value of all remuneration paid in any medium other than cash. The term includes but is not limited to:

(a) commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and periods of sickness;

(b) backpay or any similar pay made for or in regard to previous service by the employee for the employer, other than retirement or pension benefits from a qualified plan;

(c) tips or other gratuities received by the employee, to the extent that tips or gratuities are documented by the employee to the employer for tax purposes;

(d) income or payment in the form of a draw, wage, net profit, or substitute for money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration;

(e) board, lodging, rent, or housing if it constitutes a part of the employee's remuneration and is based on its actual value; and

(f) payments made to an employee on any basis other than time worked, including but not limited to piecework, an incentive plan, or profit-sharing arrangement.

(2) The term "wages" does not include any of the following:

(a) employee expense reimbursements or allowances for meals, lodging, travel, subsistence, and other expenses, as set forth in department rules;

(b) the amount of the payment made by the employer for employees, if the payment was made for:

(i) retirement or pension pursuant to a qualified plan as defined under the provisions of the Internal Revenue Code;

(ii) sickness or accident disability under a workers' compensation policy;

(iii) medical or hospitalization expenses in connection with sickness or accident disability, including health insurance for the employee or the employee's immediate family;

(iv) death, including life insurance for the employee or the employee's immediate family;

(c) vacation or sick leave benefits accrued but not paid;

(d) special rewards for individual invention or discovery; or

(e) monetary and other benefits paid to a person as part of public assistance, as defined in 53-4-201.

(3) (a) Except as provided in subsection (3)(b), for compensation benefit purposes, the average actual earnings for the four pay periods immediately preceding the injury are the employee's wages, except that if the term of employment for the same employer is less than four pay periods, the employee's wages are the hourly rate times the number of hours in a week for which the employee was hired to work.

(b) For good cause shown, if the use of the last four pay periods does not accurately reflect the

claimant's employment history with the employer, the wage may be calculated by dividing the total earnings for an additional period of time, not to exceed 1 year prior to the date of injury, by the number of weeks in that period, including periods of idleness or seasonal fluctuations.

(4) (a) For the purpose of calculating compensation benefits for an employee working concurrent employments, the average actual wages must be calculated as provided in subsection (3). As used in this subsection, "concurrent employment" means employment in which the employee was actually employed at the time of the injury and would have continued to be employed without a break in the term of employment if not for the injury.

(b) Except as provided in 39-71-118(7)(c), the compensation benefits for a covered volunteer must be based on the average actual wages in the volunteer's regular employment, except self-employment as a sole proprietor or partner who elected not to be covered, from which the volunteer is disabled by the injury incurred.

(c) The compensation benefits for an employee working at two or more concurrent remunerated employments must be based on the aggregate of average actual wages of all employments, except for the wages earned by individuals while engaged in the employments outlined in 39-71-401(3)(a) who elected not to be covered, from which the employee is disabled by the injury incurred.

(5) For the purposes of calculating compensation benefits for an employee working for an employer, as provided in 39-71-117(1)(d), and for calculating premiums to be paid by that employer, the wages must be based upon all hours worked multiplied by the mean hourly wage by area, as published by the department in the edition of Montana Informational Wage Rates by Occupation, adopted annually by the department, that is in effect as of the date of injury or for the period in which the premium is due."

Section 8. Section 39-71-201, MCA, is amended to read:

"39-71-201. Administration fund. (1) A workers' compensation administration fund is established out of which are to be paid upon lawful appropriation all costs of administering the Workers' Compensation Act and the statutory occupational safety acts that the department is required to administer, with the exception of the certification of independent contractors provided for in Title 39, chapter 71, part 4, the subsequent injury fund provided for in 39-71-907, and the uninsured employers' fund provided for in 39-71-503. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-107, 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and

(b) all fees paid by an assessment ~~of 3% of~~ on paid losses, plus administrative fines and interest

provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay ~~a~~ its proportionate share determined by the paid losses in the preceding calendar year of all costs of administering and regulating the Workers' Compensation Act and the statutory occupational safety acts that the department is required to administer, with the exception of the certification of independent contractors provided for in Title 39, chapter 71, part 4, the subsequent injury fund provided for in 39-71-907, and the uninsured employers' fund provided for in 39-71-503. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment ~~is equal~~ may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer ~~or $500, whichever is greater~~. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment ~~is equal~~ may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) By April 30 of each year, the department shall notify employers described in subsections (5)(a) and (5)(b) of the percentage of the assessment that comprises the compensation plan No. 1 proportionate share of administrative and regulatory costs. Payment of the assessment provided for by this subsection (5) must be paid

by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment ~~is equal~~ may be up to 3% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge ~~is equal~~ may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and may be up to 3% of paid losses for

claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30 of each year, the department, in consultation with the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the ~~3% of~~ assessment on the paid losses paid in the preceding year. Any excess amount collected ~~in excess of the 3%~~ must be deducted from the amount to be collected as a premium surcharge in the following year. The amount collected that is less than the ~~3%~~ assessed amount must be added to the amount to be collected as a premium surcharge in the following year.

(8) ~~On or before April 30 of each year, upon a determination by the department,~~ By July 1, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment ~~equal~~ of up to 3% of paid losses paid in the preceding calendar year~~, subject to a minimum assessment of $500, that is due on July 1~~. The department shall determine and notify the insurer by April 30 of each year the amount that is due by July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under

compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration fund must be made after being approved by the department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

Section 9. Section 39-71-307, MCA, is amended to read:

"39-71-307. Employers and insurers to file reports -- penalty. (1) Every employer insured by a plan No. 2 or a plan No. 3 insurer is required to file with the employer's insurer, under rules adopted by the department, a full and complete report of every accident, injury, or occupational disease to an employee arising out of or in the course of employment.

(2) Every insurer transacting business under this chapter shall, under rules adopted by the department, make and file with the department the reports of every injury or occupational disease.

(3) An employer~~,~~ or insurer~~, or claims examiner~~ who refuses or neglects to submit the reports necessary for the proper filing and review of a claim, as provided in subsection (1) or (2), shall be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. An employer or insurer may contest a penalty assessment in a hearing conducted according to department rules."

Section 10. Section 39-71-501, MCA, is amended to read:

"39-71-501. Definition of uninsured employer. (1) For the purposes of 39-71-501, 39-71-503 through 39-71-511, and 39-71-515 through 39-71-520, "uninsured employer" means an employer who has not properly complied with the provisions of 39-71-401.

(2) "Uninsured employer" does not include the following employers who, with their employees, are not

subject to coverage under this part:

(a) out-of-state employers excepted from this chapter under 39-71-402;

(b) an employer who is an enrolled tribal member or an association, business, corporation, or other entity at least 51% of which is owned by one or more enrolled tribal members and whose business is conducted solely within the exterior boundary of an Indian reservation; or

(c) a tribal employer without an agreement with the department, as provided under [section 1], that provides workers' compensation insurance coverage for work conducted outside the exterior boundaries of an Indian reservation and that has not waived sovereign immunity."

Section 11. Section 39-71-601, MCA, is amended to read:

"39-71-601. Statute of limitation on presentment of claim -- waiver. (1) Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department~~, as the case may be,~~ within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be in writing, signed by the claimant or the claimant's representative, and presented ~~in writing~~ to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

(4) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court."

Section 12. Section 39-71-613, MCA, is amended to read:

"39-71-613. Regulation of attorney fees -- forfeiture of fee for noncompliance -- return of fee when claimant received benefits through fraud or deception. (1) When an attorney represents or acts on behalf of a claimant or any other party on any workers' compensation claim, the attorney shall submit to the department a contract of employment, on a form provided by the department, stating specifically the terms of the fee arrangement between the attorney and the claimant.

(2) The department may regulate the amount of the attorney fees in any workers' compensation case. In regulating the amount of the fees, the department shall consider:

(a) the benefits the claimant gained due to the efforts of the attorney;

(b) the time the attorney was required to spend on the case;

(c) the complexity of the case; and

(d) any other relevant matter the department may consider appropriate.

(3) An attorney who violates a provision of this section, a rule adopted under this section, or an order fixing attorney fees under this section forfeits the right to any fees that the attorney collected or was entitled to collect.

(4) If, after an attorney receives attorney fees and costs assessed against an insurer, the claimant is convicted of having obtained benefits through fraud or deception, the attorney fees and costs for obtaining the benefits must be returned to the insurer by the attorney.

(5) (a) A dispute concerning the forfeiture or return of attorney fees is considered a dispute for which the workers' compensation court has original jurisdiction and is not subject to mediation or a contested case hearing.

(b) The parties to a dispute referred to in subsection (5)(a) may voluntarily request a mediator appointed by the department and proceed to nonbinding mediation."

Section 13. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

(A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605;

(B) travel to a medical provider within the community in which the worker resides;

(C) travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the travel and treatment were required.

(e) Pursuant to rules adopted by the department, an insurer shall reimburse a catastrophically injured worker's family or, if a family member is unavailable, a person designated by the injured worker or approved by the insurer for travel assistance expenditures in an amount not to exceed $2,500 to be used as a match to those funds raised by community service organizations to help defray the costs of travel and lodging expenses incurred by the family member or designated person when traveling to be with the injured worker. These funds must be paid in addition to any travel expenses paid by an insurer for a travel companion when it is medically necessary for a travel companion to accompany the catastrophically injured worker.

(f) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

(g) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom

it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

(ii) when necessary to monitor the status of a prosthetic device; or

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable under subsection (1)(g) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

(h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) (a) The department shall annually establish a schedule of fees for medical services that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule. ~~Until the department adopts a fee schedule applicable to medical services provided by a hospital, insurers shall pay at the rate payable on June 30, 2007, for those services provided by a hospital. The rate must be adjusted by the annual percentage increase in the state's average weekly wage, as defined in 39-71-116, factoring in changes in the hospital's medical service charges.~~

(b) (i) The department may not set the rate for medical services at a rate greater than 10% above the average of the conversion factors used by up to the top five insurers or third-party administrators providing ~~disability~~ group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

(ii) The ~~top five~~ insurers or third-party administrators included under subsection (2)(b)(i) shall provide their standard conversion rates to the department.

(iii) The department may use the conversion rates only for the purpose of determining average conversion rates under this subsection (2).

(iv) The department shall maintain the confidentiality of the conversion rates.

(c) The fee schedule rates established in subsection (2)(b) ~~apply to medical services covered by the American medical association current procedural terminology codes in effect at the time the services are provided~~

~~regardless of where the services are provided~~ must be based on the following standards as adopted by the centers for medicare and medicaid services in effect at the time the services are provided, regardless of where services are provided:

(i) the American medical association current procedural terminology codes;

(ii) the healthcare common procedure coding system;

(iii) the medicare severity diagnosis-related groups;

(iv) the ambulatory payment classifications;

(v) the ratio of costs to charges for each hospital;

(vi) the national correct coding initiative edits; and

(vii) the relative value units as adjusted annually using the most recently published resource-based relative value scale.

(d) The department may establish additional coding standards ~~to be utilized~~ for use by providers when billing for medical services under this section.

(3) (a) The department may establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the utilization and treatment guidelines established by the department are correct medical treatment for the injured worker.

(b) An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

(c) The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

(4) For services available in Montana, insurers ~~are not required to~~ may pay facilities located outside Montana ~~rates that are greater than those allowed for services delivered in Montana~~ according to the workers' compensation fee schedule of the state where the medical service is performed.

(5) (a) An insurer shall within 30 days of receipt make payments, at the fee schedule rate, of medical bills for which a claim has been accepted and for which no dispute exists over the treatment provided or the liability for the condition.

(b) Any unpaid balance under this subsection (5) accrues interest at 12% a year or 1% a month or a fraction of a month. If the charge is not paid within 30 days, interest on the unpaid balance accrues from the date of the original billing.

(6) Once a determination has been made regarding the correct reimbursement amount, any overpayment made to a medical provider must be reimbursed to the insurer within 30 days of the determination. Any reimbursement amount remaining unpaid after 30 days accrues interest at 12% a year or 1% a month or a fraction of a month. Interest on the reimbursement amount remaining unpaid accrues from the date of the determination of the correct reimbursement amount.

~~(5)~~(7) For a ~~medical assistance facility or a~~ critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual and customary charge.

~~(6)~~(8) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

~~(7)~~(9) After mediation pursuant to department rules, ~~disputes~~ an unresolved dispute between an insurer and a medical service provider regarding the amount of a fee for medical services ~~must~~ may be ~~resolved by a hearing before the department upon written application of a party to the dispute~~ brought before the workers' compensation court.

~~(8)~~(10) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(b) "Visit", as used in this subsection ~~(8)~~ (10), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection ~~(8)(a)~~ (10)(a) if the visit is for treatment requested by an insurer."

Section 14. Section 39-71-711, MCA, is amended to read:

"39-71-711. Impairment evaluation -- ratings. (1) An impairment rating:

(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;

(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association;

(c) must be expressed as a percentage of the whole person; and

(d) must be established by objective medical findings.

(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a ~~medical doctor or from an evaluator who is a chiropractor~~ treating physician as defined in 39-71-116 if the injury falls within the scope of ~~chiropractic~~ the treating physician's practice. If the claimant and insurer cannot agree upon the rating, the mediation procedure in Title 39, chapter 71, part 24~~, of this chapter~~ must be followed.

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.~~

~~(4)~~(3) Disputes over impairment ratings are subject to the provisions of 39-71-605."

Section 15. Section 39-71-712, MCA, is amended to read:

"39-71-712. Temporary partial disability benefits. (1) Subject to the provisions of subsection ~~(6)~~ (5), if prior to maximum healing an injured worker has a physical restriction and is approved to return to a modified or alternative employment that the worker is able and qualified to perform and the worker suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial disability benefits.

(2) An insurer's liability for temporary partial disability must be the difference between the injured worker's average weekly wage received at the time of the injury, subject to a maximum of 40 hours a week, and the actual weekly wages earned during the period that the claimant is temporarily partially disabled, not to exceed the injured worker's temporary total disability benefit rate.

~~(3) Temporary partial disability benefits are limited to a total of 26 weeks. The insurer may extend the period of temporary partial disability payments.~~

~~(4)~~(3) Except as provided in subsection ~~(6)~~ (5), a worker is not eligible for temporary partial disability benefits or temporary total disability benefits if:

(a) the worker has been released by the treating physician to return to a modified or alternative position that the individual is able and qualified to perform with the same employer;

(b) the wages payable in the modified or alternative position, when combined with the temporary partial disability benefits, would result in an equivalent or higher wage than the worker received at the time of injury; and

(c) the worker refuses to accept the modified or alternative position. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available to the worker for any reason except for the worker's incarceration as provided for in 39-71-744, resignation, or termination for disciplinary reasons caused by a violation of the employer's policies that provide for termination of employment and if the

worker continues to be temporarily totally disabled as defined in 39-71-116.

~~(5)~~(4) Temporary partial disability may not be credited against any permanent partial disability award or settlement under 39-71-703.

~~(6)~~(5) Unless a collective bargaining agreement precludes an injured worker from working in a modified or alternative position with a different employer or includes criteria different from those outlined in this subsection ~~(6)~~ (5), an injured worker who has not reached maximum healing and who has a physical restriction may return to a modified or alternative position with a different employer at the same or a lower rate of wages as the rate paid by the employer at the time of injury if:

(a) a modified or alternative employment with the employer at the time of injury is not provided and the injured worker and that employer agree to the modified or alternative position with a different employer;

(b) a written description and all required duties of the modified or alternative position with a different employer are approved by the treating physician;

(c) both the employer at the time of injury and the injured worker agree to the type of alternative work, the alternative employer, and the terms and conditions of employment, including payment of benefits and employment taxes for the modified or alternative position with a different employer;

(d) an employee is not displaced as a result of the injured worker's placement in the modified or alternative position with a different employer; and

(e) the employer at the time of injury, the different employer, and the injured worker agree in writing to the terms and conditions, including payment of benefits, covering the injured worker for subsequent injury, unemployment insurance, employment taxes, and liability and provide a copy of the agreement to the injured employee.

~~(7)~~(6) Any additional expenses related to the modified or alternative position, including travel, equipment, or training, must be paid by either the employer at the time of injury or the different employer and may not be charged to or deducted from the wages or benefits of the injured employee.

~~(8)~~(7) Notwithstanding a written agreement between the employer at the time of injury and a different employer, the employer at the time of injury is the primary employer if a dispute over wages, benefits, employment taxes, workers' compensation insurance, or other terms or conditions of employment occurs.

~~(9)~~(8) The injured worker may refuse to accept a modified or alternative position with an employer other than the employer at the time of injury without penalty. If the injured worker is offered a modified or alternative position with a different employer, the injured worker must be given written notice of the right of refusal from the employer at the time of injury and the insurer prior to beginning work with the different employer."

Section 16. Section 39-71-727, MCA, is amended to read:

"39-71-727. Payment for prescription drugs -- limitations. (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.

(5) The department shall establish ~~annually~~ a schedule of fees for prescription drugs.

(6) ~~The~~ Except as provided in subsection (8), a pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, the terms "brand name" and "generic name" have the meanings provided in 37-7-502.

(8) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy. However, an insurer may authorize up to a 90-day supply of medications from an in-state mail service pharmacy.

(9) The provisions of this section do not apply to an agreement between a preferred provider organization and an insurer."

Section 17. Section 39-71-743, MCA, is amended to read:

"39-71-743. Assignment or attachment of payments. (1) Payments under this chapter ~~may~~ are not ~~be~~ assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law;

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to this chapter;

(d) as provided in 39-71-742; or

(e) for workers' compensation benefits payable to an injured worker to pay restitution to an insurer whenever the injured worker is subject to court-ordered restitution for theft of workers' compensation benefits. The insurer shall notify the injured worker in writing of the withholding of any court-ordered restitution from the injured worker's benefits.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is necessary to pay current child support and a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in ~~39-71-704(8)~~ 39-71-704(10), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

Section 18. Section 39-71-905, MCA, is amended to read:

"39-71-905. Certification as person with disability -- eligibility for benefits under fund. (1) A person who wishes to be certified as a person with a disability for purposes of this part shall apply to the department on forms furnished by the department. The department shall conduct an investigation and shall issue a certificate to a person who, in the department's discretion, meets the requirements for certification. A person shall apply for certification ~~before employment or within 60 days after the person becomes employed or reemployed and~~ before an injury occurs that is covered by this part. The certification is effective ~~on the date of employment or reemployment. Certification is effective on the date the application is approved for a person who applies for certification more than 60 days after employment or reemployment, but before an injury occurs~~ retroactively to the date the department received the application.

(2) If a claimant has met the provisions of subsection (1) and a subsequent claim has been accepted by an insurer, the claim is eligible for the benefits under the fund."

Section 19. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer -- employers -- definition -- collection. (1) As used in this section,

"paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount paid by the fund in the preceding fiscal year and the expenses of administration less other realized income that is deposited in the fund. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must

be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge.

(10) If the total assessment is less than ~~$500,000~~ $1 million for any year, the department may defer the assessment amount for that year and add that amount to the assessment amount for the subsequent year."

Section 20. Section 39-71-2339, MCA, is amended to read:

"39-71-2339. Cancellation of coverage -- twenty days' notice required. (1) The state fund may cancel an employer's coverage under this part for failure to report payroll or pay the premiums due or for another cause provided in the insurance policy. Cancellation may take effect only by written notice to the named insured and the department at least 20 days prior to the date of cancellation or, in cases of nonreporting of payroll or nonpayment of a premium, by failure of the employer to submit payroll reports or pay a premium within 20 days after the due date. The state fund shall notify the department of the names and effective dates of all policies canceled. However, the policy terminates on the effective date of a replacement or succeeding insurance policy issued to the insured. This section does not prevent the state fund from canceling an insurance policy before a replacement policy is issued to the insured. After the cancellation date, the employer has the same status as an employer who is not enrolled under the Workers' Compensation Act unless a replacement or succeeding insurance policy has been issued. ~~Beginning January 1, 2006, notice~~ Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the state fund's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against the state fund if it does not comply with the notice requirement in subsection (1).

(b) The penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

~~(b)~~(c) The state fund may contest the penalty assessment in a hearing conducted according to

department rules."

Section 21. Section 39-73-104, MCA, is amended to read:

"39-73-104. Eligibility requirements for benefits. Payment must be made under this chapter to any person who:

(1) has silicosis, as defined in 39-73-101, that results in the person's total disability so as to render it impossible for the person to follow continuously any substantially gainful occupation;

(2) has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) is not receiving, with respect to any month for which the person would receive a payment under this chapter, compensation under ~~39-71-115~~ 39-71-715 equal to the sum of $350."

NEW SECTION. **Section 22. Notification to tribal governments.** The secretary of state shall send a copy of [this act] to each tribal government located on the seven Montana reservations and to the Little Shell Chippewa tribe.

NEW SECTION. **Section 23. Codification instructions.** (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 4, and the provisions of Title 39, chapter 71, part 4, apply to [section 1].

(2) [Section 2] is intended to be codified as an integral part of Title 39, chapter 71, part 21, and the provisions of Title 39, chapter 71, part 21, apply to [section 2].

NEW SECTION. **Section 24. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 25. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2009.

(2) [Sections 12, 13, and 22 through 24 and this section] are effective on passage and approval.

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