SENATE BILL NO. 371

INTRODUCED BY F. MOORE

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATING TO WORKERS' COMPENSATION INSURANCE; CREATING THE MONTANA WORKERS' COMPENSATION MODERNIZATION ACT; CREATING A RESIDUAL MARKET PROGRAM AND POOL; ESTABLISHING ELIGIBILITY OF RESIDUAL MARKET EMPLOYERS FOR COVERAGE; DISSOLVING THE STATE FUND; PROVIDING FOR RUNOFF OF OPEN CLAIMS AND CLAIMS MANAGEMENT FOR STATE FUND; PROVIDING THAT STATE FUND RESERVES AND SURPLUS ARE HELD IN TRUST; ESTABLISHING A TRUST FOR PAYMENT OF CLAIMS; PROVIDING THAT STATE FUND RESERVES ARE HELD IN TRUST; PROVIDING FOR DISPOSITION UPON RUNOFF OF ALL STATE FUND CLAIMS; AMENDING SECTIONS 2-4-101, 2-4-702, 2-15-2015, 2-18-103, 2-18-601, 2-18-701, 2-18-703, 2-18-711, 5-5-223, 5-5-228, 7-33-4510, 15-30-2618, 17-1-102, 17-2-110, 17-6-203, 17-8-403, 18-4-132, 18-7-101, 19-3-1002, 33-1-1205, 33-2-1902, 33-16-1002, 33-16-1008, 33-16-1021, 33-16-1033, 39-71-102, 39-71-103, 39-71-105, 39-71-116, 39-71-118, 39-71-201, 39-71-206, 39-71-225, 39-71-307, 39-71-401, 39-71-403, 39-71-407, 39-71-417, 39-71-419, 39-71-433, 39-71-434, 39-71-435, 39-71-442, 39-71-503, 39-71-504, 39-71-505, 39-71-515, 39-71-606, 39-71-745, 39-71-915, 39-71-1050, 39-71-1101, 39-71-1505, 39-71-2211, 39-71-2323, 45-7-501, 50-71-128, AND 53-2-211, MCA; REPEALING SECTIONS 2-15-1019, 33-1-115, 33-16-1011, 33-16-1012, 39-71-2311, 39-71-2312, 39-71-2313, 39-71-2315, 39-71-2316, 39-71-2317, 39-71-2318, 39-71-2319, 39-71-2320, 39-71-2321, 39-71-2322, 39-71-2323, 39-71-2325, 39-71-2327, 39-71-2328, 39-71-2330, 39-71-2331, 39-71-2332, 39-71-2336, 39-71-2337, 39-71-2339, 39-71-2340, 39-71-2351, 39-71-2352, 39-71-2356, 39-71-2361, 39-71-2363, 39-71-2370, AND 39-71-2375, MCA; AND PROVIDING EFFECTIVE DATES; AND PROVIDING AN APPLICABILITY DATE."

WHEREAS, the Montana State Compensation Insurance Fund, as insurer of last resort for Montana employers for the past 30 years, has provided a needed backstop to ensure availability of workers' compensation; and

WHEREAS, the state fund was to be a key component of a competitive three-way market, including self-insured employers (plan No. 1), private insurance carriers (plan No. 2), and the state fund (plan No. 3); and

WHEREAS, the state fund was originally capitalized using public funds from the State of Montana general fund; and

WHEREAS, the state fund has requested and accepted public money and has used state resources available to state agencies; and

WHEREAS, in 1991, the state fund had to be rescued by the state from a $600-$700 million unfunded liability leading to the separation of the state fund into two entities, the old fund, which held the unfunded liability, and the new fund; and

WHEREAS, all Montana employers and employees participated in the rehabilitation of the old fund unfunded liability through payroll taxes; and

WHEREAS, after separation from the old fund liability, the new fund dominates the Montana workers' compensation market so completely that competition from private insurance companies is discouraged and a competitive three-way system no longer exists; and

WHEREAS, the state remains ultimately liable for the solvency of the old fund and new fund; and

WHEREAS, since 1991, the workers' compensation insurance market has evolved and matured nationwide, and the modern workers' compensation market comprises financially sound and responsible private insurers able and willing to write insurance in a competitive voluntary Montana insurance market; and

WHEREAS, some employers for a number of reasons, such as new business, poor loss experience, or the inherently dangerous nature of their work, cannot find a voluntary market insurer willing to provide them with workers' compensation insurance; and

WHEREAS, the modern private workers' compensation insurance market has created a market of last resort, a residual market, that makes an insurance program and pool of private workers' compensation insurers available to residual market employers to ensure that all have a means of meeting their statutory obligations, no employee will lack benefits, and a state will not be at risk for unfunded liabilities; and

WHEREAS, 34 states have adopted modern residual market plans; and

WHEREAS, upon establishment of a residual market and pool all Montana policyholders will be readily absorbed into the private insurance market at competitive rates; and

WHEREAS, there is no compelling reason for the state to continue operating and subsidizing an insurance company, and there are compelling reasons to modernize Montana's workers' compensation insurance market; and

WHEREAS, it is the Legislature's desire to modernize the Montana workers' compensation market by eliminating the state's operation of an insurance company, increase competition among workers' compensation insurers, reduce workers' compensation system costs, employ private insurance industry resources to establish

a residual market protection that ensures compliant workers' compensation coverage for all employers, responsibly utilize public funds accrued within the state fund, and maintain current injured worker protections; and

WHEREAS, Montana's workers' compensation rates are the 11th highest nationwide, and modernization of the Montana market will result in a reduction in system costs, rates, and premiums for workers' compensation insurance while not adversely affecting injured worker benefits; and

WHEREAS, modernization of Montana's workers' compensation insurance market will increase funds available to the state by millions of dollars through resulting premium taxes and elimination of state services and exemptions now supporting the state fund; and

WHEREAS, the surplus accumulated by the state fund is public money useful at this time to Montana, and it should be held in trust to ensure responsible administration and payment of all old fund liabilities and open state fund claims; and

WHEREAS, the remaining surplus should be the principal of a trust created and maintained for public purposes determined by this 65th Legislature.

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 6] may be cited as the "Montana Workers' Compensation Modernization Act".

NEW SECTION. **Section 2. Residual market program and pool established -- requirements -- plan No. 2 insurers required to participate -- rates -- eligibility of residual market employers for coverage.** (1) The commissioner of labor and industry shall establish a residual market program and pool, also known as compensation plan No. 4 or plan No. 4, in order to make workers' compensation coverage available to the guaranteed market. The purpose of plan No. 4 is to guarantee that any employer in this state that is unable to obtain coverage in the voluntary market that complies with the coverage requirements of this chapter may obtain coverage in plan No. 4.

(2) The commissioner shall:

(a) contract with the advisory organization designated by the commissioner of insurance under 33-16-1023(1) to implement and administer plan No. 4;

(b) request and obtain from the state compensation insurance fund all information regarding the residual

and voluntary market employers and the associated books of business insured by the state fund to relevant and necessary for the development of plan No. 4; and

(c) approve a plan of operation for plan No. 4 established under this section.

(3) The state fund shall cooperate with the commissioner and the advisory organization under 33-16-1023(1) and shall preserve and provide all information relevant and necessary for the development of plan No. 4.

(4) Plan No. 4 established under this section must:

(a) serve as the guaranteed market for this state;

(b) require each plan No. 2 insurer licensed and writing workers' compensation insurance in this state to participate in plan No. 4 in proportion to the insurer's workers' compensation voluntary premium market share in this state as a condition of the insurer's authority to engage in the business of insurance in this state. Plan No. 4 may provide that a plan No. 2 insurer may meet the insurer's obligation under this section through direct policy assignment, participation in a reinsurance pooling mechanism, or otherwise.

(c) specify the eligibility criteria and procedures for obtaining insurance through plan No. 4. The eligibility criteria may allow for an employer to obtain insurance through plan No. 4 only if the employer has been declined coverage by three plan No. 2 insurers in the voluntary market.

(d) provide for the implementation and administration of plan No. 4, including reasonable service standards, policies, forms, and contracts as applicable to plan No. 2 insurers in the voluntary market;

(e) provide for the equitable apportionment of risks among the plan No. 2 insurers required to participate in plan No. 4;

(f) require delivery of benefits to injured workers through plan No. 4 to comply with the standards and provisions of this chapter;

(g) require compliance by plan No. 4 under applicable standards of Title 33;

(h) provide rates for insurance produced through plan No. 4 that are actuarially sufficient to cover all incurred losses, operating expenses, taxes and assessments on policies issued through plan No. 4, and administrative expenses of plan No. 4 and be consistent with classification and ratemaking methodologies under Title 33, chapter 16, part 10;

(i) provide for the orderly and efficient dissolution of the state compensation insurance fund, including:

(A) transition of policies, risks, and policy obligations of the state fund to plan No. 2 or plan No. 4 insurers;

(B) transition of state fund employees to state or private employment or retirement and vest the

employees' retirement as provided in 19-2-1002; and

(C) satisfaction or termination of all state fund obligations and operations in cooperation with the department of administration under Title 2, chapter 19, part 1. The commissioner may contract for the transition of policies, risks, and obligations of the state fund with a qualified contractor, including but not limited to an insurer authorized under Title 33, a managing general agent licensed and qualified under Title 33, chapter 2, part 16, or other qualified entity or authority.

NEW SECTION. **Section 3. Residual market plan -- plan No. 2 insurers required to participate -- rates -- eligibility of residual market employers for coverage.** (1) There is a residual market plan established by the commissioner as provided in [section 2]. A plan No. 2 insurer that is authorized to write workers' compensation insurance in this state must participate in the residual market program and pool, plan No. 4.

(2) If a plan No. 2 insurer refuses to accept its equitable apportionment or the assignment under plan No. 4, the commissioner of insurance may suspend or revoke the plan No. 2 insurer's authority to issue workers' compensation insurance policies in this state.

(3) If an employer has been declined coverage by three plan No. 2 insurers in the voluntary market, the employer may obtain insurance through plan No. 4.

(4) Plan No. 4 may not be required to provide coverage to a residual market employer if the employer or the employer's principals have defaulted on an obligation under the provisions of this chapter and the obligation remains unsatisfied.

NEW SECTION. **Section 4. Dissolution of state fund.** Upon implementation of the residual market program and pool as provided in [section 3], the state fund must be dissolved as follows:

(1) the commissioner of insurance shall rescind the state fund's certificate of authority; and

(2) the commissioner of labor and industry shall:

(a) transition all policies, risks, and obligations of the state fund, compensation plan No. 3, to plan No. 2 or plan No. 4 insurers under a plan implemented under [section 2];

(b) transfer the claims administered by the state fund for administration under [section 6];

(c) deposit the state fund reserves with the board of investments as provided in [sections 6 and 7];

(d) determine and pay dividends to all policyholders as provided in former 39-71-2323;

(e) dispose of the remaining state fund surplus with the board of investments as provided in [sections

6 and 7]; and

(f) dispose of remaining state fund assets, wind up the affairs of the state fund, and dissolve the state fund as provided in this section.

(3) To implement the actions required under this section, the commissioner shall consult with:

(a) the commissioner of insurance and the advisory organization under 33-16-1023(1) regarding residual and voluntary market employers and associated books of business insured by the state fund and all state fund operations; and

(b) the department of administration regarding all other state fund operations.

(4) The commissioner may appoint a transition team to oversee any contract effecting the transition of state fund business and operations under this section, wind up state fund affairs, and dissolve the state fund.

(5) The state fund shall:

(a) preserve all information relevant and necessary to implement the actions required under this section;

(b) cooperate with and provide all information relevant and necessary to implement the actions required under this section to the commissioner of labor and industry, the commissioner of insurance, the advisory organization under 33-16-1023(1), any qualified contractor engaged by the commissioner of labor and industry under [section 5], and the commissioner's transition team; and

(c) take all actions directed by the commissioner of labor and industry to implement the requirements of this section.

NEW SECTION. **Section 5. Transition and runoff of state fund open and incurred but not reported claims.** (1) The commissioner shall make provisions for the examination, administration, and runoff of the following workers' compensation claims against and being administered by the state fund:

(a) all claims arising on or after July 1, 1990, open or incurred but not reported on the date of dissolution under [section 4];

(b) all claims arising on or after July 1, 1990, reopened under applicable provisions of law on or after the date of dissolution under [section 4]; and

(c) all claims arising before July 1, 1990, open and being administered and paid on the date of dissolution under [section 4].

(2) The commissioner shall designate an entity responsible for administering the runoff of the claims under this section. The commissioner may contract for the runoff of the claims with a qualified contractor,

including but not limited to an insurer authorized under Title 33, a managing general agent licensed and qualified under Title 33, chapter 2, part 16, or other qualified entity. The runoff may be through payment of current claim benefits and expenses as they become due or through loss portfolio transfer subject to the provisions of [section 7].

(3) As used in this section, "runoff" has the meaning provided in [section 6].

NEW SECTION. **Section 6. Runoff of open claims -- claims management -- trust for payment of claims.** (1) The commissioner shall commence examination, administration, and runoff of the open and incurred but not reported workers' compensation claims against and being administered by the state fund as provided by a plan developed under [section 5]. The claims payment, including all loss adjustments expenses and associated assessments, must be paid from funds in trust under this section.

(2) (a) A separate investment fund with the board of investments known as the state fund dissolution trust must be maintained under 17-6-203.

(b) State fund reserves deposited with the board of investments under [section 4] must be deposited in the state fund dissolution trust and maintained for the runoff of open state fund claims, including all loss adjustment expenses and associated assessments.

(c) Following the determination and payment of any dividend as provided in [section 4] and former 39-71-2323, state fund surplus deposited with the board of investments under [section 4] must be deposited in the state fund dissolution trust for the uses and purposes provided in [section 7] and this section.

(3) (a) The principal of the state fund dissolution trust is permanent and must remain in trust as provided in this section and [section 7] until the runoff of all claims is complete. All state fund dissolution trust income from the state fund dissolution trust must first be used for the runoff of state fund claims under [section 7] and this section. If the state fund dissolution trust income is insufficient to pay current claim benefits and expenses, the commissioner may authorize funds as may be necessary to be withdrawn from state fund dissolution trust principal.

(b) (i) The commissioner shall annually determine, on July 1 of each year, the required principal of the state fund dissolution trust for the following year. If the current state fund dissolution trust principal exceeds the state fund dissolution trust required principal for the following year, then 50% of the amount that exceeds the required principal may be utilized or appropriated as determined by a vote of three-fourths of the members of each house of the legislature.

(ii) The commissioner shall contract with a qualified independent actuary to determine the annual required principal for the state fund dissolution trust.

(4) Upon complete runoff and closure of all claims under this section, the remaining state fund dissolution trust principal and income, if any, must be utilized or appropriated as determined by the legislature under [section 7].

(5) The examination, administration, and runoff of the claims must comply with this chapter.

(6) As used in this section, the following definitions apply:

(a) "Required principal" means the ultimate amount necessary to meet all payments and expenses on claims under this section until runoff is complete plus an additional 20% of the ultimate amount determined.

(b) "Runoff" means the administration and payment of an incurred but not reported or open claim for workers' compensation benefits insured under compensation plan No. 3 until claim closure.

NEW SECTION. **Section 7. State fund reserves held in trust -- disposition upon runoff of all claims.** (1) The state compensation insurance fund reserves held under former Title 39, chapter 71, part 23, for open claims arising on or after July 1, 1990, and for open claims arising before July 1, 1990, and the state fund surplus must be deposited in a fund established and maintained under 17-6-203 and held in trust for the uses and purposes provided in [section 6] and this section. The trust is known as the state fund dissolution trust. The principal of the state fund dissolution trust is permanent, except as provided in [section 6(3)]. The board of investments shall manage the state fund dissolution trust as provided by law.

(2) The principal deposited to the state fund dissolution trust must remain in trust until the runoff of all claims is complete as provided in [section 6]. The board of investments shall invest the money of the trust, and the investment income must be deposited in the trust.

(3) Upon complete runoff of all claims and expenses under [section 6], the legislature may appropriate any part of the remaining state fund dissolution trust principal by a vote of three-fourths of the members of each house of the legislature. The legislature may determine the use and appropriation of 50% of the state fund dissolution trust biennial income. The remaining income must be deposited to the state fund dissolution trust principal.

Section 8. Section 2-4-101, MCA, is amended to read:

"2-4-101. Short title -- purpose -- exception. (1) This chapter is known and may be cited as the

"Montana Administrative Procedure Act".

(2) The purposes of the Montana Administrative Procedure Act are to:

(a) generally give notice to the public of governmental action and to provide for public participation in that action;

(b) establish general uniformity and due process safeguards in agency rulemaking, legislative review of rules, and contested case proceedings;

(c) establish standards for judicial review of agency rules and final agency decisions; and

(d) provide the executive and judicial branches of government with statutory directives.

~~(3) Effective July 1, 2016, this chapter does not apply to the operations of the state compensation insurance fund provided for in Title 39, chapter 71, part 23. Administrative rules adopted by the state fund board of directors prior to July 1, 2016, apply to new and renewal policies issued by the state fund that are effective prior to July 1, 2016. The state fund is subject to rules adopted by any agency that by law apply to the state fund.~~"

Section 9. Section 2-4-702, MCA, is amended to read:

"2-4-702. Initiating judicial review of contested cases. (1) (a) Except as provided in 75-2-213 and 75-20-223, a person who has exhausted all administrative remedies available within the agency and who is aggrieved by a final written decision in a contested case is entitled to judicial review under this chapter. This section does not limit use of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by statute.

(b) A party who proceeds before an agency under the terms of a particular statute may not be precluded from questioning the validity of that statute on judicial review, but the party may not raise any other question not raised before the agency unless it is shown to the satisfaction of the court that there was good cause for failure to raise the question before the agency.

(2) (a) Except as provided in 75-2-211~~,~~ and 75-2-213, ~~and subsection (2)(c) of this section,~~ proceedings for review must be instituted by filing a petition in district court within 30 days after service of the final written decision of the agency or, if a rehearing is requested, within 30 days after the written decision is rendered. Except as otherwise provided by statute or subsection ~~(2)(d)~~ (2)(c), the petition must be filed in the district court for the county where the petitioner resides or has the petitioner's principal place of business or where the agency maintains its principal office. Copies of the petition must be promptly served upon the agency and all parties of record.

(b) The petition must include a concise statement of the facts upon which jurisdiction and venue are based, a statement of the manner in which the petitioner is aggrieved, and the ground or grounds specified in 2-4-704(2) upon which the petitioner contends to be entitled to relief. The petition must demand the relief to which the petitioner believes the petitioner is entitled, and the demand for relief may be in the alternative.

~~(c) If a petition for review is filed pursuant to 33-16-1012(2)(c), the workers' compensation court, rather than the district court, has jurisdiction and the provisions of this part apply to the workers' compensation court in the same manner as the provisions of this part apply to the district court.~~

~~(d)~~(c) If a petition for review is filed challenging a licensing or permitting decision made pursuant to Title 75 or Title 82, the petition for review must be filed in the county where the facility is located or proposed to be located or where the action is proposed to occur.

(3) Unless otherwise provided by statute, the filing of the petition may not stay enforcement of the agency's decision. The agency may grant or the reviewing court may order a stay upon terms that it considers proper, following notice to the affected parties and an opportunity for hearing. A stay may be issued without notice only if the provisions of 27-19-315 through 27-19-317 are met.

(4) Within 30 days after the service of the petition or within further time allowed by the court, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review. By stipulation of all parties to the review proceedings, the record may be shortened. A party unreasonably refusing to stipulate to limit the record may be required by the court to pay the additional costs. The court may require or permit subsequent corrections or additions to the record."

Section 10. Section 2-15-2015, MCA, is amended to read:

"2-15-2015. Workers' compensation fraud investigation and prosecution office. (1) There is a workers' compensation fraud investigation and prosecution office in the department of justice. The office shall investigate and prosecute cases referred by ~~the state compensation insurance fund or~~ the department of labor and industry on behalf of the uninsured employers' fund. The office is under the supervision and control of the attorney general and consists of:

(a) one or more investigators qualified by education, training, experience, and high professional competence in investigative procedures who shall investigate violations of the provisions of Title 39, chapter 71, at the request of ~~the state compensation insurance fund or~~ the department of labor and industry on behalf of the uninsured employers' fund; and

(b) one or more attorneys licensed to practice law in Montana who shall prosecute violations of the provisions of Title 39, chapter 71. The attorneys may also assist county attorneys in prosecuting violations of Title 39, chapter 71, without charge to the county.

(2) The ~~state compensation insurance fund, the~~ department of labor and industry~~,~~ and the department of justice shall submit to the legislature for approval one proposed biennial budget for the workers' compensation fraud office. The proposed budget for staffing and related expenses must be based upon the needs of ~~the state compensation insurance fund and~~ the department of labor and industry on behalf of the uninsured employers' fund for investigating and prosecuting workers' compensation fraud."

Section 11. Section 2-18-103, MCA, is amended to read:

"2-18-103. Officers and employees excepted. Parts 1 through 3 and 10 do not apply to the following officers and employees in state government:

(1) elected officials;

(2) county assessors and their chief deputies;

(3) employees of the office of consumer counsel;

(4) judges and employees of the judicial branch;

(5) members of boards and commissions appointed by the governor, the legislature, or other elected state officials;

(6) officers or members of the militia;

(7) agency heads appointed by the governor;

(8) academic and professional administrative personnel with individual contracts under the authority of the board of regents of higher education;

(9) academic and professional administrative personnel and live-in houseparents who have entered into individual contracts with the state school for the deaf and blind under the authority of the state board of public education;

(10) investment officer, assistant investment officer, executive director, and five professional staff positions of the board of investments;

(11) four professional staff positions under the board of oil and gas conservation;

(12) assistant director for security of the Montana state lottery;

~~(13) executive director and employees of the state compensation insurance fund;~~

~~(14)~~(13) state racing stewards employed by the executive secretary of the Montana board of horseracing;

~~(15)~~(14) executive director of the Montana wheat and barley committee;

~~(16)~~(15) commissioner of banking and financial institutions;

~~(17)~~(16) training coordinator for county attorneys;

~~(18)~~(17) employees of an entity of the legislative branch consolidated, as provided in 5-2-504;

~~(19)~~(18) chief information officer in the department of administration;

~~(20)~~(19) chief business development officer and six professional staff positions in the office of economic development provided for in 2-15-218;

~~(21)~~(20) chief public defender appointed by the public defender commission pursuant to the Montana Public Defender Act, Title 47, chapter 1, and the employees in the positions listed in 47-1-201(3)(a), who are appointed by the chief public defender; and

~~(22)~~(21) chief appellate defender in the office of appellate defender."

Section 12. Section 2-18-601, MCA, is amended to read:

"2-18-601. Definitions. For the purpose of this part the following definitions apply:

(1) ~~(a)~~ "Agency" means any legally constituted department, board, or commission of state, county, or city government or any political subdivision of the state.

~~(b) The term does not mean the state compensation insurance fund.~~

(2) "Break in service" means a period of time in excess of 5 working days when the person is not employed and that severs continuous employment.

(3) "Common association" means an association of employees established pursuant to 2-18-1310 for the purposes of employer and employee participation in the plan.

(4) "Continuous employment" means working within the same jurisdiction without a break in service of more than 5 working days or without a continuous absence without pay of more than 15 working days.

(5) "Contracting employer" means an employer who, pursuant to 2-18-1310, has contracted with the department of administration to participate in the plan.

(6) "Employee" means any person employed by an agency except elected state, county, and city officials, schoolteachers, persons contracted as independent contractors or hired under personal services contracts, and student interns.

(7) "Full-time employee" means an employee who normally works 40 hours a week.

(8) "Holiday" means a scheduled day off with pay to observe a legal holiday, as specified in 1-1-216 or 20-1-305, except Sundays.

(9) "Member" means an employee who belongs to a voluntary employees' beneficiary association established under 2-18-1310.

(10) "Part-time employee" means an employee who normally works less than 40 hours a week.

(11) "Permanent employee" means a permanent employee as defined in 2-18-101.

(12) "Plan" means the employee welfare benefit plan established under Internal Revenue Code section 501(c)(9) pursuant to 2-18-1304.

(13) "Seasonal employee" means a seasonal employee as defined in 2-18-101.

(14) "Short-term worker" means:

(a) for the executive and judicial branches, a short-term worker as defined in 2-18-101; or

(b) for the legislative branch, an individual who:

(i) is hired by a legislative agency for an hourly wage established by the agency;

(ii) may not work for the agency for more than 6 months in a continuous 12-month period;

(iii) is not eligible for permanent status;

(iv) may not be hired into another position by the agency without a competitive selection process; and

(v) is not eligible to earn the leave and holiday benefits provided in this part or the group insurance benefits provided in part 7.

(15) "Sick leave" means a leave of absence with pay for:

(a) a sickness suffered by an employee or a member of the employee's immediate family; or

(b) the time that an employee is unable to perform job duties because of:

(i) a physical or mental illness, injury, or disability;

(ii) maternity or pregnancy-related disability or treatment, including prenatal care, birth, or medical care for the employee or the employee's child;

(iii) parental leave for a permanent employee as provided in 2-18-606;

(iv) quarantine resulting from exposure to a contagious disease;

(v) examination or treatment by a licensed health care provider;

(vi) short-term attendance, in an agency's discretion, to care for a relative or household member not covered by subsection (15)(a) until other care can reasonably be obtained;

(vii) necessary care for a spouse, child, or parent with a serious health condition, as defined in the Family

and Medical Leave Act of 1993; or

(viii) death or funeral attendance of an immediate family member or, at an agency's discretion, another person.

(16) "Student intern" means a student intern as defined in 2-18-101.

(17) "Temporary employee" means a temporary employee as defined in 2-18-101.

(18) "Transfer" means a change of employment from one agency to another agency in the same jurisdiction without a break in service.

(19) "Vacation leave" means a leave of absence with pay for the purpose of rest, relaxation, or personal business at the request of the employee and with the concurrence of the employer."

Section 13. Section 2-18-701, MCA, is amended to read:

"2-18-701. Definitions. As used in this part, the following definitions apply:

(1) "Dependent" has the meaning provided in 33-22-140.

(2) (a) "Employee", as the term applies to a person employed in the executive, judicial, or legislative branches of state government, means:

(i) a permanent full-time employee, as provided in 2-18-601;

(ii) a permanent part-time employee, as provided in 2-18-601, who is regularly scheduled to work 20 hours or more a week;

(iii) a seasonal full-time employee, as provided in 2-18-601, who is regularly scheduled to work 6 months or more a year or who works for a continuous period of more than 6 months a year although not regularly scheduled to do so;

(iv) a seasonal part-time employee, as provided in 2-18-601, who is regularly scheduled to work 20 hours or more a week for 6 months or more a year or who works 20 hours or more a week for a continuous period of more than 6 months a year although not regularly scheduled to do so;

(v) elected officials;

(vi) officers and permanent employees of the legislative branch;

(vii) judges and permanent employees of the judicial branch;

(viii) academic, professional, and administrative personnel having individual contracts under the authority of the board of regents of higher education or the state board of public education;

(ix) a temporary full-time employee, as provided in 2-18-601:

(A) who is regularly scheduled to work more than 6 months a year;

(B) who works for a continuous period of more than 6 months a year although not regularly scheduled to do so; or

(C) whose temporary status is defined through collective bargaining; and

(x) a temporary part-time employee, as provided in 2-18-601:

(A) who is regularly scheduled to work 20 hours or more a week for 6 months or more a year;

(B) who works 20 hours or more a week for a continuous period of more than 6 months a year although not regularly scheduled to do so; or

(C) whose temporary status is defined through collective bargaining~~; and~~

~~(xi) a part-time or full-time employee of the state compensation insurance fund. As used in this subsection, "part-time or full-time employee of the state compensation insurance fund" means an employee eligible for inclusion in the state employee group benefit plans under the rules of the department of administration~~.

(b) The term does not include a student intern, as defined in 2-18-101."

Section 14. Section 2-18-703, MCA, is amended to read:

"2-18-703. Contributions. (1) Each agency, as defined in 2-18-601, ~~and the state compensation insurance fund~~ shall contribute the amount specified in this section toward the group benefits cost.

(2) (a) For employees defined in 2-18-701 and for members of the legislature, the employer contribution for group benefits is $887 a month from January 2015 through December 2015, $976 a month from January 2016 through December 2016, and $1,054 a month from January 2017 through December 2017.

(b) For employees defined in 2-18-701 and for members of the legislature, beginning January 2018 and for each succeeding month, the cost of group benefits, including both the employer and employee contributions for group benefits and health flexible spending accounts, may not exceed the monthly amount for self-only coverage and coverage other than self-only that will trigger the excise tax under 26 U.S.C. 4980I, including any cost-of-living adjustments under 26 U.S.C. 4980I. This section limits contributions for group benefits only to the extent needed to avoid triggering the excise tax under 26 U.S.C. 4980I.

(c) For employees of the Montana university system, the employer contribution for group benefits is $887 a month from July 2014 through June 2016 and $1,054 a month from July 2016 through the earlier of:

(i) June 2018; or

(ii) the month before the first month in which the excise tax under 26 U.S.C. 4980I applies.

(d) For employees of the Montana university system, beginning the earlier of July 2018 or the first month in 2018 in which the excise tax under 26 U.S.C. 4980I applies, and for each succeeding month, the cost of group benefits, including both the employer and employee contributions for group benefits and health flexible spending accounts, may not exceed the monthly amount for self-only coverage and coverage other than self-only that will trigger the excise tax under 26 U.S.C. 4980I, including any cost-of-living adjustments under 26 U.S.C. 4980I. This section limits contributions for group benefits only to the extent needed to avoid triggering the excise tax under 26 U.S.C. 4980I.

(e) If a state employee is terminated to achieve a reduction in force, the continuation of contributions for group benefits beyond the termination date is subject to negotiation under 39-31-305 and to the protections of 2-18-1205. Permanent part-time, seasonal part-time, and temporary part-time employees who are regularly scheduled to work less than 20 hours a week are not eligible for the group benefit contribution. An employee who elects not to be covered by a state-sponsored group benefit plan may not receive the state contribution. A portion of the employer contribution for group benefits may be applied to an employee's costs for participation in Part B of medicare under Title XVIII of the Social Security Act, as amended, if the state group benefit plan is the secondary payer and medicare the primary payer.

(3) For employees of elementary and high school districts, the employer's contributions may exceed but may not be less than $10 a month.

(4) (a) For employees of political subdivisions, as defined in 2-9-101, except school districts, the employer's contributions may exceed but may not be less than $10 a month.

(b) Subject to the public hearing requirement provided in 2-9-212(2)(b), the amount in excess of the base contribution of a local government's property tax levy for contributions for group benefits as determined in subsection (4)(c) is not subject to the mill levy calculation limitation provided for in 15-10-420.

(c) (i) Subject to subsections (4)(c)(ii) and (4)(c)(iii), the base contribution is determined by multiplying the average annual contribution for each employee on July 1, 1999, times the number of employees for whom the employer makes contributions for group benefits under 2-9-212 on July 1 of each fiscal year.

(ii) If a political subdivision did not make contributions for group benefits on or before July 1, 1999, and subsequently does so, the base contribution is determined by multiplying the average annual contribution for each employee in the first year the political subdivision provides contributions for group benefits times the number of employees for whom the employer makes contributions for group benefits under 2-9-212 on July 1 of each fiscal year.

(iii) If a political subdivision has made contributions for group benefits but has not previously levied for contributions in excess of the base contribution, the political subdivision's base is determined by multiplying the average annual contribution for each employee at the beginning of the fiscal year immediately preceding the year in which the levy will first be levied times the number of employees for whom the employer made contributions for group benefits under 2-9-212 in that fiscal year.

(5) Unused employer contributions for any state employee must be transferred to an account established for this purpose by the department of administration and upon transfer may be used to offset losses occurring to the group of which the employee is eligible to be a member.

(6) Unused employer contributions for any government employee may be transferred to an account established for this purpose by a self-insured government and upon transfer may be used to offset losses occurring to the group of which the employee is eligible to be a member or to increase the reserves of the group.

(7) The laws prohibiting discrimination on the basis of marital status in Title 49 do not prohibit bona fide group insurance plans from providing greater or additional contributions for insurance benefits to employees with dependents than to employees without dependents or with fewer dependents."

Section 15. Section 2-18-711, MCA, is amended to read:

"2-18-711. Cooperative purchasing of employee benefit services and insurance products -- procedures. (1) To provide employee group benefits, an agency, as defined in 2-18-601, ~~and the state compensation insurance fund~~ may participate with other agencies, nonprofit organizations, or business entities and in voluntary disability insurance purchasing pools provided for under 33-22-1815 if the agency ~~or the state fund~~ determines that cooperative purchasing is in the agency's ~~or the state fund's~~ best interest.

(2) Cooperative purchases under this section may be conducted according to purchasing procedures developed by the participating parties if, for contracts valued at $20,000 a year or more, purchasing procedures, at a minimum, include:

(a) public notice in three major Montana newspapers of requirements for submitting bids or offers; and

(b) consideration of all submitted bids or offers.

(3) For purposes of this section, "employee" also means a schoolteacher."

Section 16. Section 5-5-223, MCA, is amended to read:

"5-5-223. Economic affairs interim committee. ~~(1)~~ The economic affairs interim committee has

administrative rule review, draft legislation review, program evaluation, and monitoring functions for the following executive branch agencies and the entities attached to agencies for administrative purposes:

~~(a)~~(1) department of agriculture;

~~(b)~~(2) department of commerce;

~~(c)~~(3) department of labor and industry;

~~(d)~~(4) department of livestock;

~~(e)~~(5) office of the state auditor and insurance commissioner;

~~(f)~~(6) office of economic development; and

~~(g) the state compensation insurance fund provided for in 39-71-2313, including the board of directors of the state compensation insurance fund established in 2-15-1019; and~~

~~(h)~~(7) the division of banking and financial institutions provided for in 32-1-211.

~~(2) The state compensation insurance fund shall annually provide to the committee a report on its budget as approved by the state compensation insurance fund board of directors.~~"

Section 17. Section 5-5-228, MCA, is amended to read:

"5-5-228. State administration and veterans' affairs interim committee. (1) The state administration and veterans' affairs interim committee has administrative rule review, draft legislation review, program evaluation, and monitoring functions for the public employee retirement plans and for the following executive branch agencies and, unless otherwise assigned by law, the entities attached to the agencies for administrative purposes:

(a) department of administration, except:

~~(i) the state compensation insurance fund provided for in 39-71-2313, including the board of directors of the state compensation insurance fund established in 2-15-1019;~~

~~(ii)~~(i) the state tax appeal board established in 2-15-1015;

~~(iii)~~(ii) the office of state public defender; and

~~(iv)~~(iii) the division of banking and financial institutions;

(b) department of military affairs; and

(c) office of the secretary of state.

(2) The committee shall:

(a) consider the actuarial and fiscal soundness of the state's public employee retirement systems, based

on reports from the teachers' retirement board, the public employees' retirement board, and the board of investments, and study and evaluate the equity and benefit structure of the state's public employee retirement systems;

(b) establish principles of sound fiscal and public policy as guidelines;

(c) as necessary, develop legislation to keep the retirement systems consistent with sound policy principles; and

(d) publish, for legislators' use, information on the public employee retirement systems that the committee considers will be valuable to legislators when considering retirement legislation.

(3) The committee may:

(a) specify the date by which retirement board proposals affecting a retirement system must be submitted to the committee for the review pursuant to subsection (1); and

(b) request personnel from state agencies, including boards, political subdivisions, and the state public employee retirement systems, to furnish any information and render any assistance that the committee may request."

Section 18. Section 7-33-4510, MCA, is amended to read:

"7-33-4510. Workers' compensation for volunteer firefighters -- definitions. (1) An employer may provide workers' compensation coverage as provided in Title 39, chapter 71, to any volunteer firefighter who is listed on a roster of service.

(2) An employer may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or ~~3~~ 4 as provided in Title 39, chapter 71.

(3) If an employer provides workers' compensation coverage as provided in this section, the employer may, upon payment of the filing fee provided for in 7-4-2631(1)(a), file a roster of service with the clerk and recorder in the county in which the employer is located and update the roster of service monthly if necessary to report changes in the number of volunteers on the roster of service. The clerk and recorder shall file the original and replace it with updates whenever necessary. The employer shall maintain the roster of service with the effective date of membership for each volunteer firefighter.

(4) For the purposes of this section, the following definitions apply:

(a) (i) "Employer" means the governing body of a fire agency organized under Title 7, chapter 33, including a rural fire district, a fire service area, a volunteer fire department, a volunteer fire company, or a

volunteer rural fire control crew.

(ii) The term does not mean a governing body of a city of the first class or second class, including a city to which 7-33-4109 applies, that provides workers' compensation coverage to employees as defined in 39-71-118.

(b) "Roster of service" means the list of volunteer firefighters who have filled out a membership card prior to performing services as a volunteer firefighter.

(c) (i) "Volunteer firefighter" means a volunteer who is on the employer's roster of service. A volunteer firefighter includes a volunteer emergency medical technician as defined in 50-6-202 who is on the roster of service. A volunteer firefighter is not required to be an active member as defined in 19-17-102.

(ii) The term does not mean an individual who is not listed on a roster of service or a member of a volunteer fire department provided for in 7-33-4109."

Section 19. Section 15-30-2618, MCA, is amended to read:

"15-30-2618. Confidentiality of tax records. (1) Except as provided in 5-12-303, 15-1-106, 17-7-111, and subsections (8) and (9) of this section, in accordance with a proper judicial order, or as otherwise provided by law, it is unlawful to divulge or make known in any manner:

(a) the amount of income or any particulars set forth or disclosed in any individual report or individual return required under this chapter or any other information secured in the administration of this chapter; or

(b) any federal return or federal return information disclosed on any return or report required by rule of the department or under this chapter.

(2) (a) The officers charged with the custody of the reports and returns may not be required to produce them or evidence of anything contained in them in an action or proceeding in a court, except in an action or proceeding:

(i) to which the department is a party under the provisions of this chapter or any other taxing act; or

(ii) on behalf of a party to any action or proceedings under the provisions of this chapter or other taxes when the reports or facts shown by the reports are directly involved in the action or proceedings.

(b) The court may require the production of and may admit in evidence only as much of the reports or of the facts shown by the reports as are pertinent to the action or proceedings.

(3) This section does not prohibit:

(a) the delivery to a taxpayer or the taxpayer's authorized representative of a certified copy of any return

or report filed in connection with the taxpayer's tax;

(b) the publication of statistics classified to prevent the identification of particular reports or returns and the items of particular reports or returns; or

(c) the inspection by the attorney general or other legal representative of the state of the report or return of any taxpayer who brings an action to set aside or review the tax based on the report or return or against whom an action or proceeding has been instituted in accordance with the provisions of 15-30-2630.

(4) The department may deliver to a taxpayer's spouse the taxpayer's return or information related to the return for a tax year if the spouse and the taxpayer filed the return with the filing status of married filing separately on the same return. The information being provided to the spouse or reported on the return, including subsequent adjustments or amendments to the return, must be treated in the same manner as if the spouse and the taxpayer filed the return using a joint filing status for that tax year.

(5) Reports and returns must be preserved for at least 3 years and may be preserved until the department orders them to be destroyed.

(6) Any offense against subsections (1) through (5) is punishable by a fine not exceeding $500. If the offender is an officer or employee of the state, the offender must be dismissed from office or employment and may not hold any public office or public employment in this state for a period of 1 year after dismissal or, in the case of a former officer or employee, for 1 year after conviction.

(7) This section may not be construed to prohibit the department from providing taxpayer return information and information from employers' payroll withholding reports to~~:~~

~~(a)~~ the department of labor and industry to be used for the purpose of investigation and prevention of noncompliance, tax evasion, fraud, and abuse under the unemployment insurance laws~~; or~~

~~(b) the state fund to be used for the purpose of investigation and prevention of noncompliance, fraud, and abuse under the workers' compensation program~~.

(8) The department may permit the commissioner of internal revenue of the United States or the proper officer of any state imposing a tax on the incomes of individuals or the authorized representative of either officer to inspect the return of income of any individual or may furnish to the officer or an authorized representative an abstract of the return of income of any individual or supply the officer with information concerning an item of income contained in a return or disclosed by the report of an investigation of the income or return of income of an individual, but the permission may be granted or information furnished only if the statutes of the United States or of the other state grant substantially similar privileges to the proper officer of this state charged with the

administration of this chapter.

(9) On written request to the director or a designee of the director, the department shall furnish:

(a) to the department of justice all information necessary to identify those persons qualifying for the additional exemption for blindness pursuant to 15-30-2114(4), for the purpose of enabling the department of justice to administer the provisions of 61-5-105;

(b) to the department of public health and human services information acquired under 15-30-2616, pertaining to an applicant for public assistance, reasonably necessary for the prevention and detection of public assistance fraud and abuse, provided notice to the applicant has been given;

(c) to the department of labor and industry for the purpose of prevention and detection of fraud and abuse in and eligibility for benefits under the unemployment compensation and workers' compensation programs information on whether a taxpayer who is the subject of an ongoing investigation by the department of labor and industry is an employee, an independent contractor, or self-employed;

(d) to the department of fish, wildlife, and parks specific information that is available from income tax returns and required under 87-2-102 to establish the residency requirements of an applicant for hunting and fishing licenses;

(e) to the board of regents information required under 20-26-1111;

(f) to the legislative fiscal analyst and the office of budget and program planning individual income tax information as provided in 5-12-303, 15-1-106, and 17-7-111. The information provided to the office of budget and program planning must be the same as the information provided to the legislative fiscal analyst.

(g) to the department of transportation farm income information based on the most recent income tax return filed by an applicant applying for a refund under 15-70-430, provided that notice to the applicant has been given as provided in 15-70-430. The information obtained by the department of transportation is subject to the same restrictions on disclosure as are individual income tax returns.

(h) to the commissioner of insurance's office all information necessary for the administration of the small business health insurance tax credit provided for in Title 33, chapter 22, part 20;

(i) to the department of commerce tax information about a taxpayer whose debt is assigned to the department of revenue for offset or collection pursuant to the terms of Title 17, chapter 4, part 1. The information provided to the department of commerce must be used for the purposes of preventing and detecting fraud or abuse and determining eligibility for grants or loans.

(j) to the superintendent of public instruction information required under 20-9-905. (Subsection (9)(j)

terminates December 31, 2023--sec. 33, Ch. 457, L. 2015.)"

Section 20. Section 17-1-102, MCA, is amended to read:

"17-1-102. Uniform accounting system and expenditure control. (1) The department shall establish a system of financial control so that the functioning of the various agencies of the state may be improved, duplications of work by different state agencies and employees may be eliminated, public service may be improved, and the cost of government may be reduced.

(2) The department shall prescribe and install a uniform accounting and reporting system for all state agencies and institutions, reporting the receipt, use, and disposition of all public money and property in accordance with generally accepted accounting principles.

(3) The uniform accounting and reporting system must contain three levels of expenditure. The first level must include general categories, such as personal services, operating expenses, equipment, capital outlay, local assistance, grants, benefits and claims, transfers, and debt service. The second level of expenditure must include specific categories of expenditures within each first-level category. The third level of expenditure must include specific items of expenditure within each category of the second level.

(4) ~~(a) Except as provided in subsection (4)(b), all~~ All state agencies, including units of the university system but excluding community colleges, shall input all necessary transactions to the accounting system prescribed in subsection (2) before the accounts are closed at the end of the fiscal year in order to present the receipt, use, and disposition of all money and property for which the agency is accountable in accordance with generally accepted accounting principles, except that for budgetary control purposes, encumbrances that are required by generally accepted accounting principles to be reported as a reservation of fund balance must be recorded as expenditures and liabilities on the accounting records in accordance with the following requirements:

~~(i)~~(a) Goods and services, grants, and local assistance that are paid for with the general fund, in whole or in part, may be encumbered. The general fund encumbrances must be reviewed by the department, and a specific extension plan must be presented by the encumbering agency to the department prior to the fiscal yearend. If a valid extension plan is not received and approved, the department shall delete the encumbrance at fiscal yearend. The department shall present a fiscal yearend report to the office of budget and program planning and to the legislative fiscal analyst on each general fund encumbrance remaining at fiscal yearend. The report must be provided in an electronic format.

~~(ii)~~ (b) Nongeneral fund encumbrances also require a valid extension plan approved by the department

at the end of each fiscal year. After 3 years, approved extensions must be included by the department in its fiscal yearend report to the office of budget and program planning and to the legislative finance committee.

~~(b) The state fund provided for in Title 39, chapter 71, part 23, shall report on a calendar year basis.~~"

Section 21. Section 17-2-110, MCA, is amended to read:

"17-2-110. Fiscal year and financial reports. (1) ~~Except for the state fund provided for in Title 39, chapter 71, part 23, the~~ The fiscal year for state purposes commences on July 1 of each year and ends on June 30 of each year. ~~The state fund's fiscal year starts on January 1 of each year and ends on December 31 of that same year.~~

(2) At the end of each fiscal year, the fiscal records of each state office, department, bureau, commission, institution, university unit, and agency, collectively referred to as "state agency", must be closed. Each state agency shall prepare the financial records and reconciliations for the fiscal year as the department of administration may prescribe. The financial reports of the uniform accounting and reporting system prescribed in 17-1-102(2) are to be completed and distributed not more than 31 days following the end of each fiscal year. The department of administration may extend this time limit if a state agency can show necessity for the extension.

(3) The reports are to be distributed to the department of administration and the legislative auditor and any other state agency that the department of administration may prescribe. It is the intent of this provision that these reports accurately and comprehensively present the financial activities of the reporting state agency in accordance with generally accepted accounting principles so that the reports can be effectively used by the executive and legislative branches of state government.

(4) Upon consolidation of the reports, the annual financial report by the department of administration must be available for other individuals and organizations interested in the financial affairs of the state of Montana."

Section 22. Section 17-6-203, MCA, is amended to read:

"17-6-203. Separate investment funds. Separate investment funds must be maintained as follows:

(1) the permanent funds, including all public school funds and funds of the Montana university system and other state institutions of learning referred to in Article X, sections 2 and 10, of the Montana constitution. The principal and any part of the principal of each fund constituting the Montana permanent fund type are subject to deposit at any time when due under the statutory provisions applicable to the fund and according to the provisions

of the gift, donation, grant, legacy, bequest, or devise through or from which the particular fund arises.

(2) a separate investment fund, which may not be held jointly with other funds, for money pertaining to each retirement or insurance system maintained by the state, including:

(a) the public employees' retirement system described in Title 19, chapter 3;

(b) the judges' retirement system described in Title 19, chapter 5;

(c) the highway patrol officers' retirement system described in Title 19, chapter 6;

(d) the sheriffs' retirement system described in Title 19, chapter 7;

(e) the game wardens' and peace officers' retirement system described in Title 19, chapter 8;

(f) the municipal police officers' retirement system described in Title 19, chapter 9;

(g) the firefighters' unified retirement system described in Title 19, chapter 13;

(h) the Volunteer Firefighters' Compensation Act under Title 19, chapter 17;

(i) the teachers' retirement system described in Title 19, chapter 20; and

(j) the workers' compensation program described in ~~Title 39, chapter 71, part 23~~ [sections 1 through 6];

(3) a pooled investment fund, including all other accounts within the treasury fund structure established by 17-2-102;

(4) the fish and wildlife mitigation trust fund established by 87-1-611;

(5) a fund consisting of gifts, donations, grants, legacies, bequests, devises, and other contributions made or given for a specific purpose or under conditions expressed in the gift, donation, grant, legacy, bequest, devise, or contribution to be observed by the state of Montana. If a gift, donation, grant, legacy, bequest, devise, or contribution permits investment and is not otherwise restricted by its terms, it may be treated jointly with other gifts, donations, grants, legacies, bequests, devises, or contributions.

(6) a fund consisting of coal severance taxes allocated to the coal severance tax trust fund under Article IX, section 5, of the Montana constitution. The principal of the coal severance tax trust fund is permanent. If the legislature appropriates any part of the principal of the coal severance tax trust fund by a vote of three-fourths of the members of each house, the appropriation or investment may create a gain or loss in the principal.

(7) a Montana tobacco settlement trust fund established in accordance with Article XII, section 4, of the Montana constitution and Title 17, chapter 6, part 6; and

(8) additional investment funds that are expressly required by law or that the board of investments determines are necessary to fulfill fiduciary responsibilities of the state with respect to funds from a particular source."

Section 23. Section 17-8-403, MCA, is amended to read:

"17-8-403. False claims -- procedures -- penalties. (1) Except as provided in subsection (2), a person is liable to a governmental entity for a civil penalty of not less than $5,500 and not more than $11,000 for each act specified in this section, plus three times the amount of damages that a governmental entity sustains, along with expenses, costs, and attorney fees, if the person:

(a) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;

(b) knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;

(c) conspires to commit a violation of this subsection (1);

(d) has possession, custody, or control of public property or money used or to be used by the governmental entity and knowingly delivers or causes to be delivered less than all of the property or money;

(e) is authorized to make or deliver a document certifying receipt of property used or to be used by the governmental entity and, with the intent to defraud the governmental entity or to willfully conceal the property, makes or delivers a receipt without completely knowing that the information on the receipt is true;

(f) knowingly buys or receives as a pledge of an obligation or debt public property of the governmental entity from any person who may not lawfully sell or pledge the property;

(g) knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to a governmental entity or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a governmental entity; or

(h) as a beneficiary of an inadvertent submission of a false or fraudulent claim to the governmental entity, subsequently discovers the falsity of the claim or that the claim is fraudulent and fails to disclose the false or fraudulent claim to the governmental entity within a reasonable time after discovery of the false or fraudulent claim.

(2) In a civil action brought under 17-8-405 or 17-8-406, a court shall assess a civil penalty of not less than $5,500 and not more than $11,000 for each act specified in this section, plus not less than two times and not more than three times the amount of damages that a governmental entity sustains if the court finds all of the following:

(a) The person committing the act furnished the government attorney with all information known to that person about the act within 30 days after the date on which the person first obtained the information.

(b) The person fully cooperated with any investigation of the act by the government attorney.

(c) At the time that the person furnished the government attorney with information about the act, a criminal prosecution, civil action, or administrative action had not been commenced with respect to the act and the person did not have actual knowledge of the existence of an investigation into the act.

(3) A person who violates the provisions of this section is also liable to the governmental entity for the expenses, costs, and attorney fees of the civil action brought to recover the penalty or damages.

(4) Liability under this section is joint and several for any act committed by two or more persons.

(5) This section does not apply to ~~claims, records, or statements made in relation to claims filed with the state compensation insurance fund under Title 39, chapter 71, or to~~ claims, records, payments, or statements made under the tax laws contained in Title 15 or 16 or made to the department of natural resources and conservation under Title 77.

(6) (a) A court shall dismiss an action or claim brought under 17-8-406, unless opposed by the governmental entity or unless the action is brought by the government attorney or the person who is the original source of the information, if substantially the same allegations or transactions alleged in the action or claim were publicly disclosed in:

(i) a criminal, civil, or administrative hearing in which the governmental entity or an agent of the governmental entity is a party;

(ii) a state legislative, state auditor, or other governmental entity report, hearing, audit, or investigation; or

(iii) the news media.

(b) The production of a record pursuant to Article II, section 9, of the Montana constitution or 2-6-1003 is not a public disclosure for purposes of this section.

(c) For purposes of this subsection (6), "original source" means an individual who:

(i) prior to a public disclosure, voluntarily disclosed to the governmental entity the information on which the allegations or transactions in a claim are based; or

(ii) has knowledge that is independent of and materially adds to the publicly disclosed allegations and transactions and voluntarily provided the information to the governmental entity before filing an action.

(7) A person may not file a complaint or civil action brought under 17-8-406 against the state or an officer or employee of the state arising from conduct by the officer or employee within the scope of the officer's or employee's duties to the state unless the officer or employee has a financial interest in the conduct upon which

the complaint or civil action arises.

(8) The amount of the civil penalty set forth in subsections (1) and (2) must be adjusted for inflation in a manner consistent with the Federal Civil Penalties Inflation Adjustment Act of 1990, Public Law 101-410.

(9) If a governmental entity does not intervene, the person who initiated the action has the same right to conduct the action as the government attorney would have had if the governmental entity had intervened, including the right to inspect government records and interview officers and employees of the governmental entity."

Section 24. Section 18-4-132, MCA, is amended to read:

"18-4-132. Application. (1) This chapter applies to:

(a) the expenditure of public funds irrespective of their source, including federal assistance money, by this state acting through a governmental body under any contract, except a contract exempted from this chapter by this section or by another statute;

(b) a procurement of supplies or services that is at no cost to the state and from which income may be derived by the vendor and to a procurement of supplies or services from which income or a more advantageous business position may be derived by the state; and

(c) the disposal of state supplies.

(2) This chapter or rules adopted pursuant to this chapter do not prevent any governmental body or political subdivision from complying with the terms and conditions of any grant, gift, bequest, or cooperative agreement.

(3) This chapter does not apply to:

(a) either grants or contracts between the state and its political subdivisions or other governments, except as provided in part 4;

(b) construction contracts;

(c) expenditures of or the authorized sale or disposal of equipment purchased with money raised by student activity fees designated for use by the student associations of the university system;

(d) contracts entered into by the Montana state lottery that have an aggregate value of less than $250,000;

~~(e) contracts entered into by the state compensation insurance fund to procure insurance-related services;~~

~~(f)~~(e) employment of:

(i) a registered professional engineer, surveyor, real estate appraiser, or registered architect;

(ii) a physician, dentist, pharmacist, or other medical, dental, or health care provider;

(iii) an expert witness hired for use in litigation, a hearings officer hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or an attorney as specified by executive order of the governor;

(iv) consulting actuaries;

(v) a private consultant employed by the student associations of the university system with money raised from student activity fees designated for use by those student associations;

(vi) a private consultant employed by the Montana state lottery;

(vii) a private investigator licensed by any jurisdiction;

(viii) a claims adjuster; or

(ix) a court reporter appointed as an independent contractor under 3-5-601;

~~(g)~~(f) electrical energy purchase contracts by the university of Montana or Montana state university, as defined in 20-25-201. Any savings accrued by the university of Montana or Montana state university in the purchase or acquisition of energy must be retained by the board of regents of higher education for university allocation and expenditure.

~~(h)~~(g) the purchase or commission of art for a museum or public display;

~~(i)~~(h) contracting under 47-1-216 of the Montana Public Defender Act; or

~~(j)~~(i) contracting under Title 90, chapter 4, part 11.

(4) (a) Food products produced in Montana may be procured by either standard procurement procedures or by direct purchase. Montana-produced food products may be procured by direct purchase when:

(i) the quality of available Montana-produced food products is substantially equivalent to the quality of similar food products produced outside the state;

(ii) a vendor is able to supply Montana-produced food products in sufficient quantity; and

(iii) a bid for Montana-produced food products either does not exceed or reasonably exceeds the lowest bid or price quoted for similar food products produced outside the state. A bid reasonably exceeds the lowest bid or price quoted when, in the discretion of the person charged by law with the duty to purchase food products for a governmental body, the higher bid is reasonable and capable of being paid out of that governmental body's existing budget without any further supplemental or additional appropriation.

(b) The department shall adopt any rules necessary to administer the optional procurement exception established in this subsection (4).

(5) As used in this section, the following definitions apply:

(a) "Food" means articles normally used by humans as food or drink, including articles used for components of articles normally used by humans as food or drink.

(b) "Produced" means planted, cultivated, grown, harvested, raised, collected, processed, or manufactured."

Section 25. Section 18-7-101, MCA, is amended to read:

"18-7-101. Power to contract for printing -- exception. (1) Except as provided in 1-11-301, the department has exclusive power, subject to the approval of the governor, to contract for all printing for any purpose used by the state in any state office (elective or appointive), agency, or institution.

(2) The department shall supervise and attend to all public printing of the state as provided in this chapter and shall prevent duplication and unnecessary printing.

(3) Unless otherwise provided by law, the department, in letting contracts as provided in this chapter, for the printing, binding, and publishing of all laws, journals, and reports of the state agencies and institutions may determine the quantity, quality, style, and grade of all such printing, binding, and publishing.

~~(4) The provisions of this chapter do not apply to the state compensation insurance fund for purposes of external marketing or educational materials.~~"

Section 26. Section 19-3-1002, MCA, is amended to read:

"19-3-1002. Eligibility for disability retirement. (1) Except as provided in subsections (2) and (3), a member entering service prior to February 24, 1991, who is not eligible for service retirement or early retirement but who has at least 5 years of membership service and has become disabled while an active member is eligible for disability retirement, as provided in 19-3-1008.

(2) An active member who was hired prior to July 1, 2011, and is 60 years of age or older or was hired on or after July 1, 2011, and is 65 years of age or older and who has completed 5 years of membership service and has had a duty-related accident forcing the member to terminate employment but who has not received or is ineligible to receive workers' compensation benefits under Title 39, chapter 71, for the duty-related accident may conditionally waive the member's eligibility for a service retirement in order to be eligible for disability

retirement. The waiver is effective only upon approval by the board of the member's written application for disability retirement. The board shall determine whether a member has become disabled. ~~The board may request any information on file with the state compensation insurance fund concerning any duty-related accident. If information is not available, the board may request and the state fund shall then provide an investigative report on the disabling accident.~~

(3) (a) A member in service on February 24, 1991, has a one-time election to be covered for disability purposes under the provisions of 19-3-1008(2). This election is irrevocable and must be made in writing by the member no later than December 31, 1991. Coverage under the provisions of 19-3-1008(2) commences on the date the completed written election is received by the board or its designated representative. To be eligible for disability benefits under the provisions of this part, a member must have completed 5 years of membership service and must have become disabled while an active member.

(b) An individual who became a member after February 24, 1991, and before July 1, 2011, who has completed 5 years of membership service and has become disabled while an active member is covered for disability purposes under the provisions of 19-3-1008(2) or (3).

(4) A member hired on or after July 1, 2011, who has completed 5 years of membership service and has become disabled while an active member is covered for disability purposes under the provisions of 19-3-1008(4)."

Section 27. Section 33-1-1205, MCA, is amended to read:

"33-1-1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers -- notice exception. (1) Each insurer, independent adjuster, independent administrator, independent consultant, and independent producer shall cooperate fully with the commissioner with respect to the provisions of this part.

(2) Except as provided in subsection (4), an insurer, an officer, or an employee of the insurer, an independent adjuster, an independent administrator, an independent consultant, or an independent producer who has reason to believe that an insurance fraud has been or is being committed shall provide notice of the alleged insurance fraud to the commissioner within 60 days. A producer of an insurer who has reason to believe that an insurance fraud has been or is being committed shall report the alleged fraud to the insurer within 60 days of discovery of the alleged insurance fraud. The insurer shall review the report. If the insurer determines that there is reasonable likelihood that fraud has occurred, the insurer shall forward the report to the commissioner within 30 days of receipt of the report.

(3) Notice to the commissioner by an insurer who has reason to believe that an insurance fraud has been

committed in connection with an insurance claim, application, or policy tolls any applicable time period, for the commissioner, in any applicable insurance statute, related insurance regulation, or applicable sections of the criminal code and tolls any time period arising under 33-18-232 or 33-18-242 regarding unfair claims settlement practices.

~~(4) Notice of an alleged insurance fraud involving an insurance claim or application submitted to the state compensation insurance fund or a policy issued by the state compensation insurance fund must be made within 60 days to the fraud detection and prevention unit established pursuant to 39-71-211.~~"

Section 28. Section 33-2-1902, MCA, is amended to read:

"33-2-1902. Definitions. As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance, as described in 33-1-207, or life insurance, as described in 33-1-208;

(b) a licensed property and casualty insurer writing only disability insurance;

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts;

(d) a fraternal benefit society formed under Title 33, chapter 7; or

(e) a health service corporation formed under Title 33, chapter 30.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(8) (a) "Property and casualty insurer" means:

(i) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance, as described in 33-1-210, or casualty insurance, as described in 33-1-206;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(10) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, in which:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) ~~(i)~~ "company action level RBC" means, with respect to any insurer ~~except the state fund as provided in subsection (10)(b)(ii),~~ the product of 2 and its authorized control level RBC;

~~(ii) "company action level RBC" for the state fund is the product of 4 and its authorized control level RBC;~~

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) ~~(i)~~ "regulatory action level RBC" means~~, except for the state fund as provided in subsection (10)(d)(ii),~~ the product of 1.5 and its authorized control level RBC~~;~~

~~(ii) "regulatory action level RBC" for the state fund is the product of 3 and its authorized control level RBC~~.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in 33-2-1904(2). If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in 33-2-1903.

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide."

Section 29. Section 33-16-1002, MCA, is amended to read:

"33-16-1002. Applicability of part. This part, together and in conjunction with parts 1 through 4 of this chapter, applies to the making of premium rates for workers' compensation insurance issued under compensation

plan No. 2 and ~~plan No. 3~~ plan No. 4 of the Workers' Compensation Act, Title 39, chapter 71, part 22 and ~~part 23,~~ [sections 1 through 6], respectively, or related employer's liability insurance, but does not apply to reinsurance."

Section 30. Section 33-16-1008, MCA, is amended to read:

"33-16-1008. Definitions. As used in this part, the following definitions apply:

(1) "Accepted actuarial standards" means the standards adopted by the casualty actuarial society in its Statement of Principles Regarding Property and Casualty Insurance Ratemaking and the Standards of Practice adopted by the actuarial standards board.

(2) (a) "Advisory organization" means a person or organization that either has two or more member insurers or is controlled either directly or indirectly by two or more insurers and that assists insurers in ratemaking-related activities.

(b) The term does not include a joint underwriting association, any actuarial or legal consultant, or any employee of an insurer or insurers under common control or management or their employees or manager. For the purposes of this subsection (2)(b), two or more insurers who have a common ownership or operate in this state under common control or management constitute a single insurer.

(3) "Classification system" means the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations, or operations of insurance policyholders.

(4) "Contingencies" means provisions in rates to recognize the uncertainty of the estimates of losses, loss adjustment expenses, other operating expenses, and investment income and profit that comprise those rates. The provisions may be explicit, including but not limited to a specific charge to reflect systematic variations of estimated costs from expected costs, or implicit, including but not limited to a consideration in selecting a single estimate from a reasonable range of estimates, or both.

(5) "Developed losses" means adjusted losses, including loss adjustment expenses, using accepted actuarial standards to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss payments, including loss adjustment expense payments.

(6) "Expenses" means the portion of a rate that is attributable to acquisition, filed supervision and collection expenses, general expenses and taxes, licenses, or fees.

(7) "Experience rating" means a rating procedure using past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience

of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(8) "Insurer" means a person licensed to write workers' compensation insurance as a plan No. 2 or plan No. 4 insurer ~~or plan No. 3, the state fund,~~ under the laws of the state.

(9) "Loss trending" means a procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective, including loss ratio trending.

(10) "Market" means the interaction in this state between buyers and plan No. 2 and plan No. 4 sellers of workers' compensation and employer's liability insurance pursuant to the provisions of this part.

(11) (a) "Prospective loss costs" means historical aggregate losses and loss adjustment expenses, including all assessments that are loss-based and excluding any separately stated policyholder surcharges, projected through development to their ultimate value and through trending to a future point in time and ascertained by accepted actuarial standards.

(b) The term does not include provisions for profit or expenses other than loss adjustment expenses and assessments that are loss-based.

(12) "Pure premium rate" means the portion of the rate that represents the loss cost per unit of exposure, including loss adjustment expense.

(13) (a) "Rate" or "rates" means rate of premium, policy and membership fee, or any other charge made by an insurer for or in connection with a contract or policy of workers' compensation and employer's liability insurance, prior to application of individual risk variations based on loss or expense considerations.

(b) The term does not include minimum premiums.

(14) "Reserve estimates" means provisions for insurer obligations for future payments of loss or loss adjustment expenses.

(15) "Statistical plan" means the plan, system, or arrangement that is used in collecting data.

(16) "Supplementary rate information" means a manual or plan of rates, statistical plan, classification system, minimum premium, policy fee, rating rule, rate-related underwriting rule, and any other information needed to determine the applicable premium for an individual insured that is consistent with the purposes of this part and with rules prescribed by rule of the commissioner.

(17) "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required to be filed by the commissioner."

Section 31. Section 33-16-1021, MCA, is amended to read:

"33-16-1021. Ratemaking standards -- review by commissioner. (1) Rates may not be excessive, inadequate, or unfairly discriminatory.

(2) ~~(a) Except as provided in subsection (2)(b), rates~~ Rates in a competitive market are not excessive. Rates in a noncompetitive market are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services rendered.

~~(b) Rates for the state fund may not be determined to be excessive unless the rate clearly is likely to produce an excess of assets over what is reasonably necessary to pay developed losses, contingencies, expenses, and a reasonable level of surplus.~~

(3) A rate may not be determined to be inadequate unless:

(a) the rate is clearly insufficient to sustain projected losses and expenses;

(b) the rate is unreasonably low and the use of the rate by the insurer has had or, if continued, will tend to create a monopoly in the market; or

(c) funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are not produced when prospective loss costs are applied to anticipated payrolls.

(4) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with different loss exposures or expense levels.

(5) In determining whether rates comply with standards under subsection (1), consideration must be given to:

(a) past and prospective loss experience within and outside Montana, in accordance with accepted actuarial principles;

(b) catastrophe hazards and contingencies;

(c) past and prospective expenses within and outside Montana;

(d) loadings for leveling premium rates over time for dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) a reasonable margin for underwriting profit; and

(f) all other relevant factors within and outside Montana.

(6) The systems of expense provisions included in the rates for use by an insurer or group of insurers

may differ from those of any other insurer or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

(7) The rate may contain provisions of contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of a profit, consideration must be given to all investment income attributable to premiums and the reserves associated with those premiums.

(8) The commissioner may investigate and determine whether rates in Montana are excessive, inadequate, or unfairly discriminatory. In any investigation and determination, the commissioner shall also consider the factors specified in 33-16-1020."

Section 32. Section 33-16-1033, MCA, is amended to read:

"33-16-1033. Advisory organization -- permitted activity. An advisory organization may:

(1) develop statistical plans, including class definitions;

(2) collect statistical data from members, subscribers, or any other source;

(3) prepare and distribute pure premium rate data, adjusted for loss development and loss trending, in accordance with its statistical plan. The data and adjustments must be in sufficient detail to permit insurers to modify pure premiums based upon their own rating methods or interpretations of underlying data.

(4) prepare and distribute manuals for rating rules and rating schedules that do not contain any rules or schedules, including final rates, without information outside the manuals;

(5) distribute information that is filed with the commissioner and open to public inspection;

(6) conduct research and collect statistics in order to discover, identify, and classify information relating to causes or prevention of losses;

(7) prepare and file policy forms and endorsements and consult with members, subscribers, and others relative to their use and application;

(8) collect, compile, and distribute past and current prices of individual insurers, if the information is made available to the general public;

(9) conduct research and collect information to determine the impact of benefit level changes on pure premium rates;

(10) prepare and distribute rules and rating values for the uniform experience rating plan; ~~and~~

(11) calculate and disseminate individual risk premium modification factors. Individual risk premium modification factors may only be disseminated to:

(a) a licensed producer or an insurer for the business of insurance only; and

(b) the department of labor and industry for regulatory purposes only. Individual employer payroll and loss information may be provided to a person other than the current licensed producer or an insurer only after obtaining the employer's written permission; and

(12) contract with the commissioner of labor and industry to administer the state's residual market program and pool under [sections 1 through 6]."

Section 33. Section 39-71-102, MCA, is amended to read:

"39-71-102. Reference to plans. Whenever compensation plan No. 1, 2, or ~~3~~ 4 is referred to, ~~such~~ the reference also includes all other sections ~~which~~ that are applicable to the subject matter of ~~such~~ the reference."

Section 34. Section 39-71-103, MCA, is amended to read:

"39-71-103. Compensation provisions. The compensation provisions of this chapter, whenever referred to, shall be held to include the provisions of compensation plan No. 1, 2, or ~~3~~ 4 and all other sections of this chapter applicable to the same or any part thereof."

Section 35. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying this chapter, the following is the public policy of this state:

(1) An objective of the Montana workers' compensation system is to provide, without regard to fault, wage-loss and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole but are intended to provide assistance to a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) It is the intent of the legislature to assert that a conclusive presumption exists that recognizes that a holder of a current, valid independent contractor exemption certificate issued by the department is an independent contractor if the person is working under the independent contractor exemption certificate. The holder of an independent contractor exemption certificate waives the rights, benefits, and obligations of this chapter unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or ~~3~~ 4.

(3) A worker's removal from the workforce because of a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, an objective of the workers' compensation system is to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(4) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(5) This chapter must be construed according to its terms and not liberally in favor of any party.

(6) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known that the worker's condition resulted from an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

Section 36. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions ~~by the state fund~~ under the Workers' Compensation Act necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (4)(a) through (4)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (4)(a) through (4)(e), does not exist.

(5) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(6) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(7) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(8) (a) "Claims examiner" means an individual who, as a paid employee of the department, of a plan No. 1, 2, or ~~3~~ 4 insurer, ~~or~~ of an administrator licensed under Title 33, chapter 17, or of a designated entity under [section 5] examines claims under chapter 71 to:

(i) determine liability;

(ii) apply the requirements of this title;

(iii) settle workers' compensation or occupational disease claims; or

(iv) determine survivor benefits.

(b) The term does not include an adjuster as defined in 33-17-102.

(9) "Commissioner" means the commissioner of labor and industry provided for in 2-15-1701.

~~(9)~~(10) (a) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual.

(b) The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

~~(10)~~(11) "Days" means calendar days, unless otherwise specified.

~~(11)~~(12) "Department" means the department of labor and industry.

~~(12)~~(13) "Direct result" means that a diagnosed condition was caused or aggravated by an injury or occupational disease.

~~(13)~~(14) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(15) "Guaranteed market" means the residual market program and pool that is required to insure any residual market employer in this state that requests to insure its liability for workers' compensation and occupational disease coverage and is eligible to obtain the coverage from the residual market program and pool.

~~(14)~~(16) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

~~(15)~~(17) (a) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work.

(b) The term does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

~~(16)~~(18) (a) "Indemnity benefits" means any payment made directly to the worker or the worker's beneficiaries, other than a medical benefit. The term includes payments made pursuant to a reservation of rights.

(b) The term does not include stay-at-work/return-to-work assistance, auxiliary benefits, or expense

reimbursements for items such as meals, travel, or lodging.

~~(17)~~(19) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the ~~state fund under compensation plan No. 3~~ residual market program and pool, plan No. 4.

~~(18)~~(20) "Invalid" means one who is physically or mentally incapacitated.

~~(19)~~(21) "Limited liability company" has the meaning provided in 35-8-102.

~~(20)~~(22) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

~~(21)~~(23) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical healing" means a point in the healing process when further material functional improvement would not be reasonably expected from primary medical services.

~~(22)~~(24) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

~~(23)~~(25) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity.

~~(24)~~(26) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at by the department.

~~(25)~~(27) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(26)~~(28) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(27)~~(29) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment, as determined by the sixth edition of the American medical association's Guides to the Evaluation of Permanent Impairment, that is established by objective medical findings for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease and may not be based exclusively on complaints of pain.

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

~~(28)~~(30) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(29)~~(31) "Primary medical services" means treatment prescribed by the treating physician, for conditions resulting from the injury or occupational disease, necessary for achieving medical stability.

~~(30)~~(32) "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(31)~~(33) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(32)~~(34) "Reasonably safe tools or appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

~~(33)~~(35) "Regular employment" means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state.

(36) "Residual market program and pool" means the program provided for in [sections 1 through 6] that serves as the market of the last resort for the guaranteed market in this state. It is also known as compensation plan No. 4 or plan No. 4.

(37) "Residual market employer" means an eligible employer that is unable to obtain workers' compensation insurance in the usual manner through the voluntary insurance market in this state.

~~(34)~~(38) (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or

rehabilitation facilities.

(b) (i) As used in this subsection ~~(34)~~ (38), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(35)~~(39) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

(40) "State compensation insurance fund" or "state fund" means a nonprofit, independent public corporation established in former 39-71-2313 to provide workers' compensation and occupational disease coverage. It is also known as compensation plan No. 3 or plan No. 3.

~~(36)~~(41) "State's average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department before July 1 and rounded to the nearest whole dollar number.

~~(37)~~(42) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(38)~~(43) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(39)~~(44) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(40)~~(45) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(41)~~(46) "Treating physician" means the person who, subject to the requirements of 39-71-1101, is primarily responsible for delivery and coordination of the worker's medical services for the treatment of a worker's compensable injury or occupational disease and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(41)(a)~~ (46)(a), in the area where the physician assistant is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections ~~(41)(a) through (41)(e)~~ (46)(a) through (46)(e) who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8.

(47) "Voluntary market" means the workers' compensation insurance market in which workers' compensation insurance companies voluntarily offer coverage to applicants who meet the insurer's underwriting standards or guidelines.

~~(42)~~(48) "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(43)~~(49) "Year", unless otherwise specified, means calendar year."

Section 37. Section 39-71-118, MCA, is amended to read:

"39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency medical technician 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 53-30-132;

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

(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) subject to subsection (11), a member of a religious corporation, religious organization, or religious trust while performing services for the religious corporation, religious organization, or religious trust, as described in 39-71-117(1)(d).

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

(a) 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;

(b) 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)(b), "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.

(c) 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.

(d) performing temporary agricultural work for an employer if the person performing the work is otherwise exempt from the requirement to obtain workers' compensation coverage under 39-71-401(2)(r) with respect to a company that primarily performs agricultural work at a fixed business location or under 39-71-401(2)(d) and is not required to obtain an independent contractor's exemption certificate under 39-71-417 because the person does not regularly perform agricultural work away from the person's own fixed business location. For the purposes of this subsection, the term "agricultural" has the meaning provided in 15-1-101(1)(a).

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter a volunteer as defined in subsection (2)(b) or a volunteer firefighter as defined in 7-33-4510.

(4) (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 (4)(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 (4)(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.

(5) (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) For the purposes of an election under this subsection (5), 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 $200 a week and not more than 1 1/2 times the state's average weekly wage.

(6) Except as provided in Title 39, chapter 8, 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).

(7) 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.

(8) 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 (8)(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.

(9) An insurer may require coverage for all nonresident employees of a Montana employer who do not meet the requirements of subsection (8)(b) or (8)(d) as a condition of approving the election under subsection (8)(d).

(10) (a) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as

an employee within the provisions of this chapter a volunteer emergency medical technician who serves public safety through the ambulance service not otherwise covered by subsection (1)(g) or the paid or volunteer nontransporting medical unit. The ambulance service or nontransporting medical unit may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or ~~3~~ 4 as provided in this chapter.

(b) If there is an election under subsection (10)(a), the employer shall report payroll for all volunteer emergency medical technicians for premium and weekly benefit purposes based on the number of volunteer hours of each emergency medical technician, but no more than 60 hours, times the state's average weekly wage divided by 40 hours.

(c) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, may make a separate election to provide benefits as described in this subsection (10) to a member who is either a self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer emergency medical technician pursuant to subsection (10)(a). When injured in the course and scope of employment as a volunteer emergency medical technician, a member may instead of the benefits described in subsection (10)(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. If the separate election is made as provided in this subsection (10), payroll information for those self-employed sole proprietors or partners must be reported and premiums must be assessed on the assumed weekly wage.

(d) A volunteer emergency medical technician who receives workers' compensation coverage under this section may not receive disability benefits under Title 19, chapter 17, if the individual is also eligible as a volunteer firefighter.

(e) (i) The term "volunteer emergency medical technician" means a person who has received a certificate issued by the board of medical examiners as provided in Title 50, chapter 6, part 2, and who serves the public through an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county.

(ii) The term does not include a volunteer emergency medical technician who serves an employer as defined in 7-33-4510.

(f) The term "volunteer hours" means the time spent by a volunteer emergency medical technician in the service of an employer or as a volunteer for a town, city, or county, including but not limited to training time, response time, and time spent at the employer's premises.

(11) The definition of "employee" or "worker" in subsection (1)(i) is limited to implementing the administrative purposes of this chapter and may not be interpreted or construed to create an employment relationship in any other context."

Section 38. Section 39-71-201, MCA, is amended to read:

"39-71-201. Workers' compensation 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, 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, and 39-71-2205~~, and 39-71-2337~~; and

(b) all fees paid by an assessment 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,~~ the residual market program and pool 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~~,~~ or compensation plan No. 2~~, or compensation plan No. 3, the state fund,~~ and each residual market employer enrolled under compensation plan No. 4 shall pay its proportionate share determined by the paid losses in the preceding calendar year of all costs of administering and regulating the Workers' Compensation Act, 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,~~ the entity designated to administer and pay claims under [section 5] shall pay from the state fund dissolution trust provided for in [section 6] a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990, and open claims of the state fund as provided in [section 6].

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 4% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer. 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 may be up to 4% 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. 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,~~ The entity designated to administer and pay claims under [section 5] shall pay from the state fund dissolution trust provided in [section 6] an assessment to fund administrative and regulatory costs attributable to open claims of the state fund arising before July 1, 1990, and all open claims arising on or after July 1, 1990, as provided in [section 6]. The assessment may be up to 4% 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) 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~~ assessment is not timely paid 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% against the state fund dissolution trust under [section 6]. 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,~~ or plan No. 4 shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and plan No. 4 and ~~by plan No. 3, the state fund,~~ from each employer that ~~it insures~~ they insure. 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 may be up to 4% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 or plan No. 4 insurers ~~and may be up to 4% 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~~ 4 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. ~~3~~ 4, 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~~ 4 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 and plan No. 4 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 assessment on the paid losses paid in the preceding year. Any excess amount collected 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 assessed amount must be added to the amount to be collected as a premium surcharge in the following year.

(8) By July 1, an insurer under compensation plan No. 2 or compensation plan No. 4 that paid benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment of up to 4% of paid losses paid in the preceding calendar year. The department shall determine and notify the insurer by April 30 of each year of 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 39. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department ~~and state fund~~ -- investigative and prosecution services. ~~(1)~~ The attorney general is the legal adviser of the department ~~and the state fund~~ and shall represent ~~either entity~~ the department in all proceedings if requested by the department ~~or state fund~~. The department ~~and state fund~~ may employ other attorneys or legal advisers as ~~they consider~~ it considers necessary.

~~(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of this chapter.~~"

Section 40. Section 39-71-225, MCA, is amended to read:

"39-71-225. Workers' compensation database system. (1) The department shall develop a workers' compensation database system to generate management information about Montana's workers' compensation system. The database system must be used to collect and compile information from insurers, employers, health care providers, claimants, claims examiners, rehabilitation providers, and the legal profession.

(2) Data collected must be used to provide:

(a) management information to the legislative and executive branches for the purpose of making policy and management decisions, including but not limited to:

(i) performance information to enable the state to enact remedial efforts to ensure quality, control abuse, and enhance cost control;

(ii) information on medical, indemnity, and rehabilitation costs, utilization, and trends;

(iii) information on litigation and attorney involvement for the purpose of identifying trends, problem areas, and the costs of legal involvement;

(b) current and prior claim information to any insurer that is at risk on a claim, or that is alleged to be at risk in any administrative or judicial proceeding, to determine claims liability or for fraud investigation. The department may release information only upon written request by the insurer and may disclose only the claimant's name, claimant's identification number, prior claim number, date of injury, body part involved, and name and

address of the insurer and claims examiner on each claim filed. Information obtained by an insurer pursuant to this section must remain confidential and may not be disclosed to a third party except to the extent necessary for determining claim liability or for fraud investigation.

(c) current and prior claim information to law enforcement agencies for purposes of fraud investigation or prosecution; and

(d) to any insurer that is at risk on a claim, information identifying whether the claimant has been certified by the department as a person with a disability. Information obtained by an insurer pursuant to this subsection (2)(d) must remain confidential and may not be disclosed to a third party except as necessary to implement the provisions of Title 39, chapter 71, part 9. An insurer may disclose to the employer that the claimant has been certified by the department and of the potential for a limit on the insurer's liability and of potential reimbursement by the subsequent injury fund.

(3) The department is authorized to collect from insurers, employers, medical providers, the legal profession, and others the information necessary to generate the workers' compensation database system.

(4) The workers' compensation database system must be designed in accordance with the following principles:

(a) avoidance of duplication and inconsistency;

(b) reasonable availability of data elements;

(c) value of information collected to be commensurate with the cost of retrieving the collected information;

(d) uniformity to permit efficiency of collection and to allow interstate comparisons;

(e) a workable mechanism to ensure the accuracy of the data collected and to protect the confidentiality of collected data;

(f) reasonable availability of the data at a fair cost to the user;

(g) a broad application to plan No. 1, plan No. 2, and plan No. ~~3~~ 4 insurers;

(h) compatibility with electronic data reporting;

(i) reporting procedures that can be handled through private data collection systems that adhere to the provisions of subsections (4)(a) through (4)(h);

(j) implementation of reporting requirements that allow reasonable lead time for compliance.

(5) The department shall publish an annual report on the information compiled.

(6) Users of information obtained from the workers' compensation database under this section are liable for damages arising from misuse or unlawful dissemination of database information.

(7) An insurer or a third-party administrator who submitted 50 or more "first reports of injury" to the department in the preceding calendar year shall electronically submit the reports and any other reports related to the reported claims in a nationally recognized format specified by department rule.

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

Section 41. 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~~ 4 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 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 42. Section 39-71-401, MCA, is amended to read:

"39-71-401. Employments covered and exemptions -- elections -- notice. (1) Except as provided in subsection (2), the Workers' Compensation Act applies to all employers and to all employees. An employer who has any employee in service under any appointment or contract of hire, expressed or implied, oral or written, shall elect to be bound by the provisions of compensation plan No. 1, 2, or ~~3~~ 4 [unless the provisions of 39-71-442 apply]. Each employee whose employer is bound by the Workers' Compensation Act is subject to and bound by the compensation plan that has been elected by the employer.

(2) Unless the employer elects coverage for these employments under this chapter and an insurer allows an election, the Workers' Compensation Act does not apply to any of the following:

(a) household or domestic employment;

(b) casual employment;

(c) employment of a dependent member of an employer's family for whom an exemption may be claimed by the employer under the federal Internal Revenue Code;

(d) employment of sole proprietors, working members of a partnership, working members of a limited liability partnership, or working members of a member-managed limited liability company, except as provided in subsection (3);

(e) employment of a real estate, securities, or insurance salesperson paid solely by commission and without a guarantee of minimum earnings;

(f) employment as a direct seller as defined by 26 U.S.C. 3508;

(g) employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States;

(h) employment of a person performing services in return for aid or sustenance only, except employment of a volunteer under 67-2-105;

(i) employment with a railroad engaged in interstate commerce, except that railroad construction work is included in and subject to the provisions of this chapter;

(j) employment as an official, including a timer, referee, umpire, or judge, at an amateur athletic event;

(k) employment of a person performing services as a newspaper carrier or freelance correspondent if the person performing the services or a parent or guardian of the person performing the services in the case of a minor has acknowledged in writing that the person performing the services and the services are not covered. As used in this subsection (2)(k):

(i) "freelance correspondent" means a person who submits articles or photographs for publication and is paid by the article or by the photograph; and

(ii) "newspaper carrier":

(A) means a person who provides a newspaper with the service of delivering newspapers singly or in bundles; and

(B) does not include an employee of the paper who, incidentally to the employee's main duties, carries or delivers papers.

(l) cosmetologist's services and barber's services as referred to in 39-51-204(1)(e);

(m) a person who is employed by an enrolled tribal member or an association, business, corporation, or other entity that is at least 51% owned by an enrolled tribal member or members, whose business is conducted solely within the exterior boundaries of an Indian reservation;

(n) employment of a jockey who is performing under a license issued by the board of horseracing from the time that the jockey reports to the scale room prior to a race through the time that the jockey is weighed out

after a race if the jockey has acknowledged in writing, as a condition of licensing by the board of horseracing, that the jockey is not covered under the Workers' Compensation Act while performing services as a jockey;

(o) employment of a trainer, assistant trainer, exercise person, or pony person who is performing services under a license issued by the board of horseracing while on the grounds of a licensed race meet;

(p) employment of an employer's spouse for whom an exemption based on marital status may be claimed by the employer under 26 U.S.C. 7703;

(q) a person who performs services as a petroleum land professional. As used in this subsection, a "petroleum land professional" is a person who:

(i) is engaged primarily in negotiating for the acquisition or divestiture of mineral rights or in negotiating a business agreement for the exploration or development of minerals;

(ii) is paid for services that are directly related to the completion of a contracted specific task rather than on an hourly wage basis; and

(iii) performs all services as an independent contractor pursuant to a written contract.

(r) an officer of a quasi-public or a private corporation or, except as provided in subsection (3), a manager of a manager-managed limited liability company who qualifies under one or more of the following provisions:

(i) the officer or manager is not engaged in the ordinary duties of a worker for the corporation or the limited liability company and does not receive any pay from the corporation or the limited liability company for performance of the duties;

(ii) the officer or manager is engaged primarily in household employment for the corporation or the limited liability company;

(iii) the officer or manager either:

(A) owns 20% or more of the number of shares of stock in the corporation or owns 20% or more of the limited liability company; or

(B) owns less than 20% of the number of shares of stock in the corporation or limited liability company if the officer's or manager's shares when aggregated with the shares owned by a person or persons listed in subsection (2)(r)(iv) total 20% or more of the number of shares in the corporation or limited liability company; or

(iv) the officer or manager is the spouse, child, adopted child, stepchild, mother, father, son-in-law, daughter-in-law, nephew, niece, brother, or sister of a corporate officer who meets the requirements of subsection (2)(r)(iii)(A) or (2)(r)(iii)(B);

(s) a person who is an officer or a manager of a ditch company as defined in 27-1-731;

(t) service performed by an ordained, commissioned, or licensed minister of a church in the exercise of the church's ministry or by a member of a religious order in the exercise of duties required by the order;

(u) service performed to provide companionship services, as defined in 29 CFR 552.6, or respite care for individuals who, because of age or infirmity, are unable to care for themselves when the person providing the service is employed directly by a family member or an individual who is a legal guardian;

(v) employment of a person performing the services of an intrastate or interstate common or contract motor carrier when hired by an individual or entity who meets the definition of a broker or freight forwarder, as provided in 49 U.S.C. 13102;

(w) employment of a person who is not an employee or worker in this state as defined in 39-71-118(8);

(x) employment of a person who is working under an independent contractor exemption certificate;

(y) employment of an athlete by or on a team or sports club engaged in a contact sport. As used in this subsection, "contact sport" means a sport that includes significant physical contact between the athletes involved. Contact sports include but are not limited to football, hockey, roller derby, rugby, lacrosse, wrestling, and boxing.

(z) a musician performing under a written contract.

(3) (a) (i) A person who regularly and customarily performs services at locations other than the person's own fixed business location shall elect to be bound personally and individually by the provisions of compensation plan No. 1, 2, or ~~3~~ 4 unless the person has waived the rights and benefits of the Workers' Compensation Act by obtaining an independent contractor exemption certificate from the department pursuant to 39-71-417.

(ii) Application fees or renewal fees for independent contractor exemption certificates must be deposited in the state special revenue account established in 39-9-206 and must be used to offset the certification administration costs.

(b) A person who holds an independent contractor exemption certificate may purchase a workers' compensation insurance policy and with the insurer's permission elect coverage for the certificate holder.

(c) For the purposes of this subsection (3), "person" means:

(i) a sole proprietor;

(ii) a working member of a partnership;

(iii) a working member of a limited liability partnership;

(iv) a working member of a member-managed limited liability company; or

(v) a manager of a manager-managed limited liability company that is engaged in the work of the

construction industry as defined in 39-71-116.

(4) (a) A corporation or a manager-managed limited liability company shall provide coverage for its employees under the provisions of compensation plan No. 1, 2, or ~~3~~ 4. A quasi-public corporation, a private corporation, or a manager-managed limited liability company may elect coverage for its corporate officers or managers, who are otherwise exempt under subsection (2), by giving a written notice in the following manner:

(i) if the employer has elected to be bound by the provisions of compensation plan No. 1, by delivering the notice to the board of directors of the corporation or to the management organization of the manager-managed limited liability company; or

(ii) if the employer has elected to be bound by the provisions of compensation plan No. 2 or ~~3~~ 4, by delivering the notice to the board of directors of the corporation or to the management organization of the manager-managed limited liability company and to the insurer.

(b) If the employer changes plans or insurers, the employer's previous election is not effective and the employer shall again serve notice to its insurer and to its board of directors or the management organization of the manager-managed limited liability company if the employer elects to be bound.

(5) The appointment or election of an employee as an officer of a corporation, a partner in a partnership, a partner in a limited liability partnership, or a member in or a manager of a limited liability company for the purpose of exempting the employee from coverage under this chapter does not entitle the officer, partner, member, or manager to exemption from coverage.

(6) Each employer shall post a sign in the workplace at the locations where notices to employees are normally posted, informing employees about the employer's current provision of workers' compensation insurance. A workplace is any location where an employee performs any work-related act in the course of employment, regardless of whether the location is temporary or permanent, and includes the place of business or property of a third person while the employer has access to or control over the place of business or property for the purpose of carrying on the employer's usual trade, business, or occupation. The sign must be provided by the department, distributed through insurers or directly by the department, and posted by employers in accordance with rules adopted by the department. An employer who purposely or knowingly fails to post a sign as provided in this subsection is subject to a $50 fine for each citation. (Bracketed language in subsection (1) terminates June 30, 2019--sec. 5, Ch. 315, L. 2015.)"

Section 43. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan ~~three exclusive~~ for state agencies -- election of plan by public corporations -- financing of self-insurance fund -- exemption for university system -- definitions -- rulemaking. (1) ~~(a) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.~~

~~(b) (i)~~(a) Subject to subsection (5), the department of administration, provided for in 2-15-1001, shall obtain and manage workers' compensation insurance coverage for all state agencies.

~~(ii) The state fund shall provide the department of administration with all information regarding the state agencies' coverage.~~

~~(iii) Notwithstanding the status of a state agency as employer in subsection (1)(a) and contingent upon mutual agreement between the department of administration and the state fund, the state fund shall issue one or more policies for all state agencies.~~

~~(iv)~~(b) In any year in which the workers' compensation premium due from a state agency is lower than in the previous year, the appropriation for that state agency must be reduced by the same amount that the workers' compensation premium was reduced and the difference must be returned to the originating fund instead of being applied to other purposes by the state agency submitting the premium.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. ~~3~~ 4, separately or jointly with any other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary. The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection (3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) For the purposes of subsection (1)(b), the judicial branch or the legislative branch may choose not to have the department of administration manage its workers' compensation policy.

(6) The department of administration may adopt rules to implement subsection (1)(b)(i).

(7) As used in this section, the following definitions apply:

(a) "Public corporation" includes the Montana university system.

(b) (i) "State agency" means:

(A) the executive branch and its departments and all boards, commissions, committees, bureaus, and offices;

(B) the judicial branch; and

(C) the legislative branch.

(ii) The term does not include the Montana university system."

Section 44. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer covered under plan No. 1, plan No. 2, ~~and the state fund under plan No. 3~~ or plan No. 4 that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) An injury does not arise out of and in the course of employment when the employee is:

(a) on a paid or unpaid break, is not at a worksite of the employer, and is not performing any specific tasks for the employer during the break; or

(b) engaged in a social or recreational activity, regardless of whether the employer pays for any portion of the activity. The exclusion from coverage of this subsection (2)(b) does not apply to an employee who, at the time of injury, is on paid time while participating in a social or recreational activity or whose presence at the activity is required or requested by the employer. For the purposes of this subsection (2)(b), "requested" means the employer asked the employee to assume duties for the activity so that the employee's presence is not completely voluntary and optional and the injury occurred in the performance of those duties.

(3) (a) An insurer is liable for an injury, as defined in 39-71-119, only if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury has occurred and aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(4) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(5) Except as provided in subsection (6), an employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident.

(6) (a) An employee who has received written certification, as defined in 50-46-302, from a physician for the use of marijuana for a debilitating medical condition and who is otherwise eligible for benefits payable under this chapter is subject to the limitations of subsections (6)(b) through (6)(d).

(b) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of marijuana for a debilitating medical condition, as defined in 50-46-302, is the major contributing cause of the injury or occupational disease.

(c) Nothing in this chapter may be construed to require an insurer to reimburse any person for costs associated with the use of marijuana for a debilitating medical condition, as defined in 50-46-302.

(d) In an accepted liability claim, the benefits payable under this chapter may not be increased or enhanced due to a worker's use of marijuana for a debilitating medical condition, as defined in 50-46-302. An insurer remains liable for those benefits that the worker would qualify for absent the worker's use of marijuana for a debilitating medical condition.

(7) The provisions of subsection (5) do not apply if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs not prescribed by a physician. This subsection (7) does not apply to the use of marijuana for a debilitating medical condition because marijuana is not a prescribed drug.

(8) If there is no dispute that an insurer is liable for an injury but there is a liability dispute between two or more insurers, the insurer for the most recently filed claim shall pay benefits until that insurer proves that another insurer is responsible for paying benefits or until another insurer agrees to pay benefits. If it is later

proven that the insurer for the most recently filed claim is not responsible for paying benefits, that insurer must receive reimbursement for benefits paid to the claimant from the insurer proven to be responsible.

(9) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(10) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

(11) For occupational diseases, every employer enrolled under plan No. 1~~,~~ and every insurer under plan No. 2~~,~~ or ~~the state fund under plan No. 3~~ plan No. 4 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the ~~state fund under plan No. 3~~ plan No. 4 if the employee is diagnosed with a compensable occupational disease.

(12) An insurer is liable for an occupational disease only if the occupational disease:

(a) is established by objective medical findings; and

(b) arises out of or is contracted in the course and scope of employment. An occupational disease is considered to arise out of or be contracted in the course and scope of employment if the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease.

(13) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(14) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a health care provider; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

(15) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with

respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

(16) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 45. Section 39-71-417, MCA, is amended to read:

"39-71-417. Independent contractor certification. (1) (a) (i) Except as provided in subsection (1)(a)(ii), a person who regularly and customarily performs services at a location other than the person's own fixed business location shall apply to the department for an independent contractor exemption certificate unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or ~~3~~ 4.

(ii) An officer or manager who is exempt under 39-71-401(2)(r)(iii) or (2)(r)(iv) may apply, but is not required to apply, to the department for an independent contractor exemption certificate.

(b) A person who meets the requirements of this section and receives an independent contractor exemption certificate is not required to obtain a personal workers' compensation insurance policy.

(c) For the purposes of this section, "person" means:

(i) a sole proprietor;

(ii) a working member of a partnership;

(iii) a working member of a limited liability partnership;

(iv) a working member of a member-managed limited liability company; or

(v) a manager of a manager-managed limited liability company that is engaged in the work of the construction industry as defined in 39-71-116.

(2) The department shall adopt rules relating to an original application for or renewal of an independent contractor exemption certificate. The department shall adopt by rule the amount of the fee for an application or certificate renewal. The application or renewal must be accompanied by the fee.

(3) The department shall deposit the application or renewal fee in an account in the state special revenue fund to pay the costs of administering the program.

(4) (a) To obtain an independent contractor exemption certificate, the applicant shall swear to and acknowledge the following:

(i) that the applicant has been and will continue to be free from control or direction over the performance

of the person's own services, both under contract and in fact; and

(ii) that the applicant is engaged in an independently established trade, occupation, profession, or business and will provide sufficient documentation of that fact to the department.

(b) For the purposes of subsection (4)(a)(i), an endorsement required for licensure, as provided in 37-47-303, does not imply or constitute control.

(5) (a) An applicant for an independent contractor exemption certificate shall submit an application under oath on a form prescribed by the department and containing the following:

(i) the applicant's name and address;

(ii) the applicant's social security number;

(iii) each occupation for which the applicant is seeking independent contractor certification; and

(iv) other documentation as provided by department rule to assist in determining if the applicant has an independently established business.

(b) The department shall adopt a retention schedule that maintains copies of documents submitted in support of an initial application or renewal application for an independent contractor exemption certificate for a minimum of 3 years after an application has been received by the department. The department shall, to the extent feasible, produce renewal applications that reduce the burden on renewal applicants to supply information that has been previously provided to the department as part of the application process.

(c) An applicant who applies on or after July 1, 2011, to renew an independent contractor exemption certificate is not required to submit documents that have been previously submitted to the department if:

(i) the applicant certifies under oath that the previously submitted documents are still valid and current; and

(ii) the department, if it considers it necessary, independently verifies a specific document or decides that a document has not expired pursuant to the document's own terms and is therefore still valid and current.

(6) The department shall issue an independent contractor exemption certificate to an applicant if the department determines that an applicant meets the requirements of this section.

(7) (a) When the department approves an application for an independent contractor exemption certificate and the person is working under the independent contractor exemption certificate, the person's status is conclusively presumed to be that of an independent contractor.

(b) A person working under an approved independent contractor exemption certificate has waived all rights and benefits under the Workers' Compensation Act and is precluded from obtaining benefits unless the

person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or ~~3~~ 4.

(c) For the purposes of the Workers' Compensation Act, a person is working under an independent contractor exemption certificate if:

(i) the person is performing work in the trade, business, occupation, or profession listed on the person's independent contractor exemption certificate; and

(ii) the hiring agent and the person holding the independent contractor exemption certificate do not have a written or an oral agreement that the independent contractor exemption certificate holder's status with respect to that hiring agent is that of an employee.

(8) Once issued, an independent contractor exemption certificate remains in effect for 2 years unless:

(a) suspended or revoked pursuant to 39-71-418; or

(b) canceled by the independent contractor.

(9) If the department's independent contractor central unit denies an application for an independent contractor exemption certificate, the applicant may contest that decision as provided in 39-71-415(2)."

Section 46. Section 39-71-419, MCA, is amended to read:

"39-71-419. Independent contractor violations -- penalty. (1) A person may not:

(a) perform work as an independent contractor without first:

(i) obtaining from the department an independent contractor exemption certificate unless the individual is not required to obtain an independent contractor exemption certificate pursuant to 39-71-417(1)(a); or

(ii) electing to be bound personally and individually by the provisions of compensation plan No. 1, 2, or ~~3~~ 4;

(b) perform work as an independent contractor when the department has revoked or denied the independent contractor's exemption certificate;

(c) transfer to another person or allow another person to use an independent contractor exemption certificate that was not issued to that person;

(d) alter or falsify an independent contractor exemption certificate; or

(e) misrepresent the person's status as an independent contractor.

(2) An employer may not:

(a) require an employee through coercion, misrepresentation, or fraudulent means to adopt independent

contractor status to avoid the employer's obligations to provide workers' compensation coverage; or

(b) exert control to a degree that causes the independent contractor to violate the provisions of 39-71-417(4).

(3) In addition to any other penalty or sanction provided in this chapter, a person or employer who violates a provision of this section is subject to a fine to be assessed by the department of up to $1,000 for each violation. The department shall deposit the fines in the uninsured employers' fund. The lien provisions of 39-71-506 apply to any assessed fines.

(4) A person or employer who disputes a fine assessed by the department pursuant to this section may file an appeal with the department within 30 days of the date on which the fine was assessed. If, after mediation, the issue is not resolved, the issue must be transferred to the workers' compensation court for resolution."

Section 47. Section 39-71-433, MCA, is amended to read:

"39-71-433. Group purchase of workers' compensation insurance. (1) Two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(2) A group formed under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state, except that the ~~state fund, as defined in 39-71-2312,~~ residual market program and pool, as defined in 39-71-116, has the right to refuse coverage of a group and its plan of operation but, subject to the eligibility requirements of the residual market program and pool, may not refuse coverage to an individual employer. Under an individual policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(3) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

(4) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, the eligibility requirements to join the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management."

Section 48. Section 39-71-434, MCA, is amended to read:

"39-71-434. Deductible insurance policy provision for medical benefits. (1) In order to lower the amount an employer is required to pay to obtain workers' compensation insurance coverage under this chapter, a workers' compensation policy issued by ~~the state compensation insurance fund under plan No. 3 or by~~ a private insurer under plan No. 2 or plan No. 4 must offer a deductible for the medical, hospital, and related services allowed under 39-71-704. The medical deductible must be offered in amounts of at least $500.

(2) If the insured employer chooses to accept a medical deductible, the insured employer is liable for the amount of the deductible for the medical benefits paid for each otherwise compensable claim of work injury suffered by an employee.

(3) The insured employer shall contract with the insurer to have the insurer pay the entire cost of the covered medical benefits directly to the provider of medical or related services and then seek reimbursement from the insured employer for the deductible amount. The insurer is entitled to reimbursement only for medical, hospital, and related services allowed under 39-71-704, up to the amount of the deductible.

(4) If an insured employer who has contracted with an insurer for a medical deductible does not pay the medical deductible amount to the insurer through reimbursement, the amount paid by the insurer on the claim may be included as benefits paid in a determination of the insured employer's rate.

(5) If an insured employer chooses to accept a medical deductible, then for purposes of computing rates and rating plans, all medical losses incurred must be reported to the insurer without regard to the application of any medical deductible regardless of whether the employer or the insurer pays the losses."

Section 49. Section 39-71-435, MCA, is amended to read:

"39-71-435. Workers' compensation and employers' liability insurance -- optional deductibles. (1) An insurer issuing a workers' compensation or an employer's liability insurance policy under compensation plan No. 2 or plan No. 4 may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) The advisory organization designated under 33-16-1023 may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the

deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.

(h) Losses subject to the deductible must be reported and recorded as losses for purposes of calculating rates for a policyholder on the same basis as losses under policies providing first dollar coverage.

~~(4) The state compensation insurance fund, plan No. 3, may adopt the plan filed by the designated advisory organization or adopt an optional deductible plan that meets the requirements of this section.~~

~~(5)~~(4) For purposes of 39-71-201, 39-71-915, and 50-71-128, liability for assessments must be ascertained without regard to application of any deductible, whether the employer or the insurer pays the losses. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible."

Section 50. Section 39-71-442, MCA, is amended to read:

"39-71-442. (Temporary) Employer option for extraterritorial coverage. (1) Notwithstanding 39-71-118(8)(a), an employee of an employer in this state who is employed by the employer to work solely in North Dakota, and who is required by the laws of that state to be covered for workers' compensation purposes while working in that state, is not considered to be an employee in this state covered under Title 39, chapter 71, during any time that the employer maintains workers' compensation coverage for the employee in North Dakota. For purposes of this section, "work solely in North Dakota" means the employee does not perform job duties in

Montana and coverage is required by the state of North Dakota. Travel that is commuting to and from a job site in North Dakota from a location in Montana does not constitute performing job duties in Montana even if the employer pays for all or a portion of the costs of travel or if the worker is paid for the travel time.

(2) A plan No. 1, 2, or ~~3~~ 4 insurer providing coverage to the employer under this chapter may require proof of coverage in North Dakota and records of work in North Dakota. An insurer may use a verification of employment form, developed by the department, to request an attestation by the employer regarding the employees working solely in North Dakota.

(3) (a) This section does not exempt an employee from coverage under this chapter when the employee's usual job duties begin in this state and the employee is otherwise covered under 39-71-407(4)(a).

(b) This section exempts an employee from coverage under this chapter when the employee is engaged in travel while commuting as provided in subsection (1). (Terminates June 30, 2019--sec. 5, Ch. 315, L. 2015.)"

Section 51. Section 39-71-503, MCA, is amended to read:

"39-71-503. Uninsured employers' fund -- purpose and administration of fund -- maintaining balance for administrative costs -- appropriation. (1) There is created an uninsured employers' fund in the state special revenue account to pay:

(a) to an injured employee of an uninsured employer the same benefits the employee would have received if the employer had been properly enrolled under compensation plan No. 1, 2, or ~~3~~ 4, except as provided in subsection (3);

(b) the costs of investigating and prosecuting workers' compensation fraud under 2-15-2015; and

(c) the expenses incurred by the department in administering the uninsured employers' fund.

(2) The department may refer to the workers' compensation fraud office, established in 2-15-2015, cases involving:

(a) false or fraudulent claims for benefits; and

(b) criminal violations of 45-7-501.

(3) (a) Except as provided in subsection (3)(b), surpluses and reserves may not be kept for the fund. The department shall make payments that it considers appropriate as funds become available from time to time. The payment of weekly disability benefits takes precedence over the payment of medical benefits. Lump-sum payments of future projected benefits, including impairment awards, may not be made from the fund. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(b) The department shall maintain at least a 3-month balance based on projected budget costs for administration of the fund. The balance for administrative costs may be used by the department only in administering the fund.

(c) The maximum aggregate medical benefits expenditure that may be made from the fund may not exceed $100,000 for any single claim regardless of whether the claim arises from an injury or an occupational disease.

(4) The amounts necessary for the payment of benefits from the fund are statutorily appropriated, as provided in 17-7-502, from the fund."

Section 52. Section 39-71-504, MCA, is amended to read:

"39-71-504. Funding of fund -- option for agreement between department and injured employee. The fund is funded in the following manner:

(1) (a) The department may require that the uninsured employer pay to the fund a penalty of either up to double the premium amount the employer would have paid on the payroll of the employer's workers in this state if the employer had been enrolled with compensation plan No. ~~3~~ 4 or $200, whichever is greater. In determining the premium amount for the calculation of the penalty under this subsection, the department shall make an assessment based on how much premium would have been paid on the employer's past 3-year payroll for periods within the 3 years when the employer was uninsured.

(b) The fund shall collect from an uninsured employer an amount equal to all benefits paid or to be paid from the fund to or on behalf of an injured employee of the uninsured employer.

(c) In addition to any amounts recovered under subsections (1)(a) and (1)(b), the fund shall collect a penalty of $200 from an employer that fails to obtain Montana workers' compensation insurance within 30 days of notice of the requirement.

(2) (a) An uninsured employer that fails to make timely penalty or claim reimbursement payments required under this part must be assessed a late fee of $50 for each late payment.

(b) Any unpaid balance owed to the fund under this part must accrue interest at 12% a year or 1% a month or fraction of a month. Interest on unpaid balances accrues from the date of the original billing.

(c) Late fees and interest assessed pursuant to this subsection (2) must be deposited into the fund for payment of administrative expenses and benefits.

(3) The department may enter into an agreement with the injured employee or the employee's

beneficiaries to assign to the employee or the beneficiaries all or part of the funds collected by the department from the uninsured employer pursuant to subsection (1)(b)."

Section 53. Section 39-71-505, MCA, is amended to read:

"39-71-505. Applicability of other provisions of chapter to fund. All appropriate provisions in the Workers' Compensation Act apply to the fund in the same manner as they apply to compensation plans No. 1, 2, and ~~3~~ 4."

Section 54. Section 39-71-515, MCA, is amended to read:

"39-71-515. Independent cause of action. (1) An injured employee or the employee's beneficiaries have an independent cause of action against an uninsured employer for failure to be enrolled in a compensation plan as required by this chapter.

(2) In an action described in subsection (1), prima facie liability of the uninsured employer exists if the claimant proves, by a preponderance of the evidence, that:

(a) the employer was required by law to be enrolled under compensation plan No. 1, 2, or ~~3~~ 4 with respect to the claimant; and

(b) the employer was not enrolled on the date of the injury or death.

(3) It is not a defense to an action that the employee had knowledge of or consented to the employer's failure to carry insurance or that the employee was negligent in permitting the failure to exist.

(4) The amount of recoverable damages in an action is the amount of compensation that the employee would have received had the employer been properly enrolled under compensation plan No. 1, 2, or ~~3~~ 4.

(5) A plaintiff who prevails in an action brought under this section is entitled to recover reasonable costs and attorney fees incurred in the action, in addition to damages."

Section 55. Section 39-71-606, MCA, is amended to read:

"39-71-606. Insurer to accept or deny claim within 30 days of receipt -- notice of benefits and entitlements to claimants -- notice of denial -- notice of reopening -- notice to employer -- employer's right to loss information. (1) Each insurer under any plan for the payment of workers' compensation benefits shall, within 30 days of receipt of a claim for compensation signed by the claimant or the claimant's representative, either accept or deny the claim and, if denied, shall inform the claimant and the department in writing of the denial.

(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlements available under Title 39, chapter 71. On receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlements available by providing the claimant a copy of the document prepared by the department.

(3) Each insurer under plan No. 2 or No. ~~3~~ 4 for the payment of workers' compensation benefits shall notify the employer of the reopening of the claim within 14 days after the reopening of a claim for the purpose of paying compensation benefits.

(4) (a) When requested by an employer that an insurer currently insures or has insured in the immediately preceding 5 years or when requested by the employer's designated insurance producer, an insurer shall provide the loss information listed in subsection (4)(b) within 10 days of the request.

(b) Loss information provided under this subsection (4) must include for the period requested:

(i) all date of injury or occupational disease data for the employer's claims;

(ii) payment data on the employer's closed claims; and

(iii) payment data and loss reserve amounts on the employer's open claims, including all compensation benefits that are ongoing and are being charged against that employer's account.

(c) The information provided under this subsection (4) is confidential insurance information. The information may be used by the employer for internal management purposes or for procuring insurance products but may not be disclosed for any other purpose without the express written consent of the insurer.

(5) Failure of an insurer to comply with the time limitations required in subsections (1) and (3) does not constitute an acceptance of a claim as a matter of law. However, an insurer who fails to comply with 39-71-608 or subsections (1) and (3) of this section may be assessed a penalty under 39-71-2907 if a claim is determined to be compensable by the workers' compensation court."

Section 56. Section 39-71-745, MCA, is amended to read:

"39-71-745. Calculation of volunteer firefighter benefits and premiums -- definitions. (1) (a) A plan No. 1, ~~or~~ plan No. 2, or plan No. 4 insurer shall designate whether an employer, as defined in 7-33-4510, is to use actual volunteer hours or a flat assumed payroll amount for each volunteer firefighter for calculating premiums. The coverage option must be the same for all fire agencies organized under Title 7, chapter 33, that are covered by that insurer and meet the definition of employer in 7-33-4510. ~~A plan No. 3 insurer shall use a flat assumed payroll amount for each volunteer firefighter for calculating premiums.~~

(b) If a plan No. 1, ~~or~~ plan No. 2, or plan No. 4 insurer uses actual volunteer hours, the payroll calculation is the number of actual volunteer hours of each volunteer firefighter, not to exceed 60 hours a week, times the state's average weekly wage divided by 40 hours.

(c) When a plan No. 1, plan No. 2, or plan No. ~~3~~ 4 insurer uses a flat assumed payroll amount, the assumed payroll for each volunteer firefighter must be reported as a full month for any month in which the volunteer firefighter is on the roster of service as defined in 7-33-4510. The employer shall maintain the roster of service with the effective date of membership for each volunteer firefighter.

(2) For benefit purposes, if concurrent employment under 39-71-123 does not apply, a volunteer firefighter injured in the course and scope of employment as a volunteer firefighter is eligible for medical and compensation benefits provided in Title 39, chapter 71. Any weekly compensation benefit must be based on either the actual volunteer hours if chosen as provided in subsection (1)(b) or the flat assumed payroll amount on which premiums are based, whichever is applicable.

(3) For the purposes of this section, the following definitions apply:

(a) "Volunteer firefighter" has the meaning provided in 7-33-4510.

(b) "Volunteer hours" means the time spent by a volunteer firefighter in the service of a fire agency organized under Title 7, chapter 33, that meets the definition of employer in 7-33-4510, including but not limited to training time, response time, and time spent at the premises of the fire agency."

Section 57. 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 or plan No. 4 insurer, ~~plan No. 3, the state fund,~~ and the state fund dissolution trust under [section 5] with respect to state fund claims arising before July 1, 1990, and open state fund claims arising on or after July

1, 1990, as provided in [section 5] ~~and each employer insured by plan No. 3, the state fund~~. The assessment amount is the total amount from April 1 of the previous year through March 31 of the current year paid by the fund plus 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. 4 employers, ~~plan No. 3, the state fund, and plan No. 3 employers,~~ and the state fund dissolution trust under [section 6] 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. 4 insurer, and ~~plan No. 3, the state fund,~~ and the entity designated under [section 5] to administer and pay claims of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the ~~state fund~~ state fund dissolution trust under [section 6] 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 and plan No. 4 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,~~ or plan No. 4 insurer 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~~ 4 in the previous calendar year. The numerator for the calculation must be adjusted as provided by

subsection (9).

(7) Each plan No. 2 and plan No. 4 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,~~ 4 insurer 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~~ entity designated under [section 5] to administer and pay claims shall pay by July 1 the portion of the assessment attributable to claims arising before July 1, 1990, ~~by July 1~~ and open claims of the state fund arising on or after July 1, 1990, as provided in [section 5].

(e) If a plan No. 1 employer, a plan No. 2 or plan No. 4 insurer, or ~~plan No. 3, the state fund,~~ the claims administrator selected under [section 5] 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 or plan No. 4 insurer, or ~~plan No. 3, the state fund,~~ the state fund dissolution trust under [section 6] 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 $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 58. Section 39-71-1050, MCA, is amended to read:

"39-71-1050. Assessment for stay-at-work/return-to-work assistance fund -- definition. (1) (a) The assistance fund must be maintained by assessing employers insured by plan No. 1, plan No. 2, and plan No. ~~3~~ 4 an amount as provided in subsections (2) through (10).

(b) The board of investments shall invest the money in the assistance fund. The investment income must be deposited in the assistance fund.

(2) The assessment amount is the total amount paid by the assistance fund in the preceding fiscal year less other realized income that is deposited in the assistance fund. Allocation of the total assessment amount among employers insured by plan No. 1, plan No. 2, and plan No. ~~3~~ 4 must be based on each plan's proportionate share of money expended from the assistance fund for the calendar year preceding the year in which the assessment is collected.

(3) On or before May 31 of each year, the department shall notify each plan No. 1 employer~~,~~ and plan No. 2 or plan No. 4 insurer~~, and plan No. 3, the state fund,~~ of the amount to be assessed for the ensuing fiscal year. On or before April 30 of each year, the department shall consult with the advisory organization designated under 33-16-1023 and notify plan No. 2 and plan No. 4 insurers ~~and plan No. 3, the state fund,~~ of the premium surcharge rate to be effective for policies written or renewed on or after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is the amount actually expended by the assistance fund on behalf of injured workers employed by that plan No. 1 employer. A group of employers insured jointly under plan No. 1 is considered to be an individual employer for the purposes of this subsection.

(5) After subtracting plan No. 1 assessments from the total assessment, the department shall determine the surcharge rate for plan No. 2 and plan No. 4 insurers ~~and plan No. 3, the state fund,~~ 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~~ 4 in the previous calendar year. The numerator for the calculation must be adjusted as provided in subsection (9).

(6) Employers insured under plan No. 2 or plan No. ~~3~~ 4 shall pay their portion of the assessment in a surcharge on premiums for policies written or renewed annually on or after July 1.

(7) (a) Each plan No. 2 and plan No. 4 insurer ~~and plan No. 3, the state fund,~~ shall collect from its policyholders the assessment premium surcharge provided for in subsection (5). 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 stay-at-work/return-to-work assistance 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 as the premium for the coverage. The assessment premium surcharge must be excluded from the definition of premium 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.

(b) 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 described in 39-71-201 first, then to the assessment premium surcharge described in 50-71-128, then to the assessment premium surcharge in this section, and then to the surcharge in 39-71-915, with any remaining amount applied to the premium due.

(8) (a) The department shall deposit all assessments due under this section into the assistance fund.

(b) Each plan No. 1 employer shall pay its assessment due under this section by July 1.

(c) Each plan No. 2 and plan No. 4 insurer ~~and plan No. 3, the state fund,~~ shall remit to the department all assessment premium surcharges collected during a calendar quarter no later than 20 days following the end of the quarter.

(d) If a plan No. 1 employer~~,~~ or a plan No. 2 or plan No. 4 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~~,~~ or the plan No. 2 or plan No. 4 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 assistance fund.

(9) Each year, the department shall compare the amount of the assessment premium surcharge actually collected pursuant to subsection (5) with 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 for the following year's assessment premium surcharge as provided in subsection (5).

(10) If the total assessment is less than $100,000 for any year, the department may defer the assessment for that year and add that amount to the assessment amount for the subsequent year.

(11) As used in this section, "money expended" means expenditures for stay-at-work/return-to-work assistance from the assistance fund."

Section 59. Section 39-71-1101, MCA, is amended to read:

"39-71-1101. Choice of health care provider by worker -- insurer designation or approval of treating physician or referral to managed care or preferred provider organization -- payment terms -- definition. (1) Prior to the insurer's designation or approval of a treating physician as provided in subsection (2) or a referral to a managed care organization or preferred provider organization as provided in subsection (8), a worker may choose a person who is listed in 39-71-116~~(41)~~(46) for initial treatment. Subject to subsection (2), if the person listed under 39-71-116~~(41)~~(46) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician.

(2) Any time after acceptance of liability by an insurer, the insurer may designate or approve a treating physician who agrees to assume the responsibilities of the treating physician. The designated or approved treating physician:

(a) is responsible for coordinating the worker's receipt of medical services as provided in 39-71-704;

(b) shall provide timely determinations required under this chapter, including but not limited to maximum medical healing, physical restrictions, return to work, and approval of job analyses, and shall provide documentation;

(c) shall provide or arrange for treatment within the utilization and treatment guidelines or obtain prior approval for other treatment; and

(d) shall conduct or arrange for timely impairment ratings.

(3) The treating physician may refer the worker to other health care providers for medical services, as provided in 39-71-704, for the treatment of a worker's compensable injury or occupational disease. A health care provider to whom the worker is referred by the designated treating physician is not responsible for coordinating care or providing determinations as required of the treating physician.

(4) The treating physician designated or approved by the insurer must be reimbursed at 110% of the department's fee schedule.

(5) A health care provider to whom the worker is referred by the treating physician must be reimbursed at 90% of the department's fee schedule.

(6) A health care provider providing health care on a compensable claim prior to the designation or approval of the treating physician by the insurer must be reimbursed at 100% of the department's fee schedule.

(7) Regardless of the date of injury, the medical fee schedule rates in effect as adopted by the department in 39-71-704 and the percentages referenced in subsections (4) through (6) of this section apply to the medical service on the date on which the medical service was provided.

(8) The insurer may direct the worker to a managed care organization or a preferred provider organization for designation of the treating physician.

(9) After the insurer directs a worker to a managed care organization or preferred provider organization, a health care provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer.

(10) After the date that a worker subject to the provisions of subsection (9) receives individual written notice of a referral, the worker must, unless otherwise authorized by the insurer, receive medical services from the organization designated by the insurer, in accordance with 39-71-1102 and 39-71-1104. The designated treating physician in the organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a health care provider who is not a member of a managed care organization or a preferred provider organization.

(11) Posting of managed care requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to a managed care organization must be provided to the worker in written form by mail or in person after the date of injury or occupational disease."

Section 60. Section 39-71-1505, MCA, is amended to read:

"39-71-1505. Rulemaking authority. The department shall adopt rules, including but not limited to rules that require:

(1) each employer to conduct an educational-based safety program, including but not limited to:

(a) a safety training program to provide:

(i) new employee general safety orientation;

(ii) job- or task-specific safety training; and

(iii) continuous refresher safety training, including periodic safety meetings;

(b) periodic hazard assessment, with corrective actions identified; and

(c) appropriate documentation of performance of the activities; and

(2) an employer of more than five employees to have a comprehensive and effective safety program, including but not limited to:

(a) subject to subsection (3), a safety committee composed of employee and employer representatives that holds regularly scheduled meetings;

(b) procedures of reporting and investigating all work-related incidents, accidents, injuries, and illnesses; and

(c) policies and procedures that assign specific safety responsibilities and safety performance accountability.

(3) The department may adopt rules authorizing:

(a) a plan No. 2 or plan No. ~~3~~ 4 insurer to waive the requirement in subsection (2)(a) for a safety committee if the employer presents sufficient evidence of an effective written safety plan and has a satisfactory modification factor, if applicable, or has a low incident record of injuries; or

(b) the department to waive the requirement in subsection (2)(a) for a safety committee if a plan No. 1 insurer approved by the department presents sufficient evidence of an effective safety program, including a written safety plan. A waiver granted under this subsection (3)(b) to a member of the self-insurers guaranty fund must be made with the concurrence of the fund."

Section 61. Section 39-71-2211, MCA, is amended to read:

"39-71-2211. Premium rates for construction industry -- filing required. (1) With respect to each

classification of risk in the construction industry under plan No. 2 and plan No. 4, the advisory organization designated under 33-16-1023 shall file with the commissioner of insurance a method of computing premiums that does not impose a higher insurance premium solely because of an employer's higher rate of wages paid.

(2) The commissioner shall accept a filing under subsection (1) that includes a reasonable method of recognizing differences in rates of pay. This method must use a credit scale with the starting point set at 1.168 times the state's average weekly wage as reported by the department.

(3) The advisory organization shall file a revenue neutral plan for new and renewed policies for prompt and orderly transition to a method of computing premiums that is in compliance with the requirements of this section.

~~(4) The state compensation insurance fund, plan No. 3, shall adopt the plan filed by the designated advisory organization or adopt a credit scale plan that meets the requirements of this section.~~"

Section 62. Section 39-71-2323, MCA, is amended to read:

"39-71-2323. Surplus in state fund -- payment of dividends. (1) Subject to the provisions of 39-71-2316, if at the end of any fiscal year there exists in the state fund account created by 39-71-2321 for claims for injuries resulting from accidents that occur on or after July 1, 1990, an excess of assets over liabilities, including necessary reserves and an appropriate surplus as determined by the board in accordance with 39-71-2330, and if the excess may be refunded safely, then the board, after consultation with the independent actuary engaged pursuant to 39-71-2330, may declare a dividend. The state fund must prescribe the manner of payment to those employers who have paid premiums into the state fund in excess of liabilities.

(2) Prior to the dissolution of the state fund as provided in [section 4], after consultation with the independent actuary, the commissioner may declare and pay a dividend to current state fund policyholders as follows:

(a) the dividend must be determined subject to the guidelines of subsection (1) and may not be greater than 5% of the required principal of state fund dissolution trust under [section 6]; and

(b) the dividend must be distributed in an equitable manner to all employers who have paid premiums into the state fund."

Section 63. Section 45-7-501, MCA, is amended to read:

"45-7-501. Employer misconduct. (1) A person who is an employer, as defined in 39-71-117, commits

the offense of employer misconduct if the person knowingly or purposely:

(a) avoids the person's responsibility to provide coverage for the person's employees as required by 39-71-401;

(b) misrepresents or falsifies employment records or information, including but not limited to understating the amount of payroll or the number of the person's employees; or

(c) refuses to pay premiums that the person is obligated to pay under compensation plan No. 2, as provided in Title 39, chapter 71, part 22, or compensation plan No. ~~3, as provided in Title 39, chapter 71, part 23~~ 4, as provided in [sections 1 through 6].

(2) A person convicted of the offense of employer misconduct shall be fined an amount not to exceed $50,000 or be imprisoned in the state prison for any term not to exceed 10 years, or both."

Section 64. Section 50-71-128, MCA, is amended to read:

"50-71-128. Occupational safety and health administration fund. (1) (a) An occupational safety and health administration fund is established, out of which are to be paid upon lawful appropriation all costs incurred by the department on or after July 1, 2016, in administering Title 50, chapters 71, 72, and 73.

(b) The department shall collect and deposit in the state treasury to the credit of the occupational safety and health administration fund:

(i) all penalties assessed under 50-71-119;

(ii) all expenses recovered under 50-72-106 and 50-73-107;

(iii) all fees paid by an assessment on paid losses, plus administrative fines and interest provided by this section; and

(iv) any grants or funds from private entities or the federal government intended for use by the department in defraying occupational safety and health costs.

(2) For the purposes of this section, the term "paid losses" has the meaning provided in 39-71-201.

(3) Each plan No. 1 employer, plan No. 2 and plan No. 4 insurer subject to the provisions of this section, and ~~plan No. 3, the state fund,~~ the entity designated to administer and pay claims under [section 5] shall file annually on March 1 in the form and containing the information required by the department a report of paid losses.

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. ~~3, the state fund,~~ 4 shall pay its proportionate share, as determined by the paid losses in the preceding calendar year, of all costs appropriated for the next fiscal year for the purposes of administering Title 50, chapters

71, 72, and 73.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 2% of the paid losses that were paid in the preceding calendar year by or on behalf of the plan No. 1 employer. 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 may be up to 2% of the paid losses that were 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. 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 occupational safety and health administration fund.

(6) (a) Each employer insured under compensation plan No. 2 or plan No. ~~3, the state fund,~~ 4 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,~~ 4, the residual market program and pool from each employer that ~~it insures~~ they insure. 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 "occupational safety and health 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 on insured employers.

(b) (i) The amount to be funded by the premium surcharge may be up to 2% of the paid losses that were paid in the preceding calendar year by or on behalf of all plan No. 2 and plan No. 4 insurers and may be up to 2% of paid losses for claims arising on or after July 1, 1990, for ~~plan No. 3,~~ the state fund being administered and paid by the entity designated under [section 5], plus or minus any adjustments as provided by subsection (6)(f).

(ii) The amount determined under subsection (6)(b)(i) must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. ~~3, the state fund,~~ 4 during the preceding calendar year.

(iii) A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. ~~3, the state fund,~~ 4 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, the state fund,~~ 4 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 and plan No. 4 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 occupational safety and health 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 assessment on the paid losses paid in the preceding year. Any excess amount collected 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 assessed amount must be added to the amount to be collected as a premium surcharge in the following year.

(7) By July 1, an insurer under compensation plan No. 2 or plan No. 4 that paid benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment of up to 2% of the paid losses that were paid in the preceding calendar year. The department shall determine and notify the insurer by April 30 of each year of the amount that is due by July 1.

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

(9) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of Title 50, chapters 71, 72, and 73, 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.

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

(11) The department may assess and collect the occupational safety and health 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 occupational safety and health administration fund."

Section 65. Section 53-2-211, MCA, is amended to read:

"53-2-211. Department to share eligibility data. (1) The department shall make available to the unemployment compensation program of the department of labor and industry all information contained in its files and records pertaining to eligibility of persons for medicaid, financial assistance and nonfinancial assistance, as defined in 53-2-902, and food stamps. The information made available must include information on the amount and source of an applicant's income. The information received from the department must be used by the department of labor and industry for the purpose of determining fraud, abuse, or eligibility for benefits under the unemployment compensation program of the ~~state~~ department and for no other purpose.

(2) The department shall make available to the unemployment compensation and workers' compensation programs of the department of labor and industry all information contained in its files and records pertaining to eligibility of persons for low-income energy assistance and weatherization. The information made available must include information on the amount and source of an applicant's income. The information received from the department must be used by the department of labor and industry for the purpose of determining fraud, abuse,

or eligibility for benefits under the unemployment compensation and workers' compensation ~~programs~~ program of the state and for no other purpose.

(3) (a) Subject to federal restrictions, the department may request information from the department of labor and industry pertaining to unemployment, workers' compensation, and occupational disease benefits. If the department of labor and industry discovers evidence relating to fraud or abuse for unemployment, workers' compensation, or occupational benefits, the department of labor and industry may request information from the department of revenue pertaining to income as provided in 15-30-2618(9)(c).

(b) The information must be used by the department for the purpose of determining fraud, abuse, or eligibility for benefits.

(4) The department may, to the extent permitted by federal law, make available to an agency of the state or to any other organization information contained in its files and records pertaining to the eligibility of persons for medicaid, financial assistance and nonfinancial assistance, as defined in 53-2-902, food stamps, low-income energy assistance, weatherization, or other public assistance."

NEW SECTION. **Section 66. Repealer.** The following sections of the Montana Code Annotated are repealed:

2-15-1019.	Board of directors of state compensation insurance fund -- legislative liaisons.
33-1-115.	Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements.
33-16-1011.	Classification review committee -- membership -- term.
33-16-1012.	Functions and powers of classification review committee -- hearings -- rulemaking.
39-71-2311.	Intent and purpose of plan -- expense constant defined.
39-71-2312.	Definitions.
39-71-2313.	State compensation insurance fund created -- obligation to insure.
39-71-2315.	Management of state fund -- powers and duties of board -- business plan required.
39-71-2316.	Powers of state fund.
39-71-2317.	Appointment of executive director -- management staff.
39-71-2318.	Personal liability excluded.
39-71-2319.	Assets and liabilities of prior state fund.
39-71-2320.	Property of state fund -- investment required -- exception.

39-71-2321.	What to be deposited in state fund.
39-71-2322.	Money in state fund held in trust -- disposition of funds upon repeal of chapter.
39-71-2323.	Surplus in state fund -- payment of dividends.
39-71-2325.	State fund to keep accounts of segregations.
39-71-2327.	Earnings of state fund to be credited to fund -- improper use a felony.
39-71-2328.	State fund alternative personal leave plan -- exception -- collective bargaining negotiation -- personal leave definition.
39-71-2330.	Rate setting -- surplus -- multiple rating tiers.
39-71-2331.	Workplace safety program.
39-71-2332.	Pooled risk safety group.
39-71-2336.	Manner of electing -- contract or policy of insurance -- payment of premium.
39-71-2337.	State fund to submit notice of coverage within 30 days -- penalty for failure.
39-71-2339.	Cancellation of coverage -- 20-day notice required.
39-71-2340.	Collection in case of default.
39-71-2351.	Purpose of separation of state fund liability as of July 1, 1990, and of separate funding of claims before and on or after that date.
39-71-2352.	Separate payment structure and sources for claims for injuries resulting from accidents that occurred before July 1, 1990, and on or after July 1, 1990 -- spending limit -- authorizing transfer of money.
39-71-2356.	Mutually agreeable lump-sum settlements.
39-71-2361.	Legislative audit of state fund.
39-71-2363.	Agency law -- annual report.
39-71-2370.	Claims expenditures codes.
39-71-2375.	Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements.

NEW SECTION. **Section 67. Transition -- commissioner of labor -- commissioner of insurance.** The actions required of the commissioner of labor and the commissioner of insurance in [sections 3, 4, 6, and 7] may not be implemented before July 1, 2018.

NEW SECTION. **Section 68. Codification instruction.** (1) [Sections 1 through 6] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 1 through 6].

(2) [Section 7] is intended to be codified as an integral part of Title 17, chapter 6, part 2, and the provisions of Title 17, chapter 6, part 2, apply to [sections 7].

NEW SECTION. **Section 69. 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 70. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 71. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2018.

(2) Except as provided in [section 67], [sections 1, 2, 5, 36, 62, 67, and 72] and this section are effective on passage and approval.

NEW SECTION. **Section 72. Applicability.** [This act] applies to applications for workers' compensation policies and to in-force or issued workers' compensation policies on or after July 1, 2017.

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