SENATE BILL NO. 108

INTRODUCED BY V. COCCHIARELLA

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW; REQUIRING INSURERS TO NOTIFY THE DEPARTMENT OF LABOR AND INDUSTRY OF CHANGES IN THIRD-PARTY CLAIMS EXAMINERS; DEPOSITING PENALTY FEES FOR FAILURE TO NOTIFY IN THE WORKERS' COMPENSATION ADMINISTRATION FUND; MODIFYING DISPUTE RESOLUTION PROCEDURES PERTAINING TO INDEPENDENT CONTRACTOR STATUS AND CERTIFICATION; MODIFYING DEPARTMENT PROCEDURES FOR ESTABLISHING ANNUAL FEE SCHEDULES FOR MEDICAL SERVICES AND PRESCRIPTION DRUGS; REVISING REIMBURSEMENT AMOUNTS FOR DOMICILIARY CARE PROVIDED BY A FAMILY MEMBER; PROVIDING THAT INTEREST ACCRUES ON AMOUNTS NOT PAID FROM SECURITY DEPOSITS WHEN PAYMENT IS DEMANDED BY THE DEPARTMENT; CLARIFYING THAT THE PENALTY FOR FAILURE TO REPORT CERTAIN INFORMATION TO THE DEPARTMENT MAY BE ASSESSED FOR EACH INSTANCE OF FAILURE TO REPORT; PROVIDING GUIDELINES FOR DETERMINING WHEN AN INSURER IS IMPAIRED; REQUIRING SECURITY FROM PLAN NO. 2 INSURERS TO COVER POTENTIAL LIABILITY; AMENDING SECTIONS 39-71-107, 39-71-201, 39-71-415, 39-71-417, 39-71-418, 39-71-704, 39-71-727, 39-71-1107, 39-71-2106, 39-71-2201, 39-71-2204, 39-71-2205, AND 39-71-2337, MCA; AND REPEALING SECTION 39-71-2208, MCA."

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

Section 1. Section 39-71-107, MCA, is amended to read:

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

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act must be examined by a claims examiner in Montana. For a claim to be considered as examined by a claims examiner in Montana, the claims examiner examining the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an office located in Montana, and examine Montana claims from that office. Use of a mailbox or

maildrop in Montana does not constitute maintaining an office in Montana.

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

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

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

~~(4)~~(5) An insurer shall provide to the claimant:

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

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

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

~~(5)~~(6) An insurer shall:

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

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

~~(6)~~(7) The department may adopt rules to implement this section.

~~(7)~~(8) (a) For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

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

Section 2. Section 39-71-201, MCA, is amended to read:

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

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

(b) all fees paid by an assessment of 3% of paid losses, plus administrative fines and interest provided by this section.

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

(a) total compensation benefits paid; and

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

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

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

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

to be the employer for the purposes of this section.

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

(c) Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

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

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

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

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

(i) one installment due on July 1; or

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

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

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers'

compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

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

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

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

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

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

(8) On or before April 30 of each year, upon a determination by the department, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment equal to 3% of paid losses paid in the preceding

calendar year, subject to a minimum assessment of $500, that is due on 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 3. Section 39-71-415, MCA, is amended to read:

"39-71-415. Procedure for resolving disputes regarding independent contractor status. ~~(1) If an individual, employer, or insurer has a dispute as to whether an individual is an independent contractor or an employee, any party may, after mediation pursuant to department rules, petition the workers' compensation court for resolution of the dispute.~~

~~(2)~~(1) If a claimant and insurer have a dispute over benefits and the dispute involves an issue of whether the claimant is an independent contractor or employee, either party may, after mediation pursuant to department rules, petition the workers' compensation judge for resolution of the dispute in accordance with 39-71-2905.

~~(3)~~(2) (a) A dispute ~~between~~ involving an employer, a worker, ~~and~~ or the department and involving the issue of whether a worker is an independent contractor or an employee, but not involving workers' compensation benefits, must be brought before the independent contractor central unit of the department for resolution.

(b) (i) A decision of the independent contractor central unit is final unless a party dissatisfied with the decision ~~appeals by filing a petition with the workers' compensation court~~ requests mediation pursuant to department rules within ~~30~~ 15 days of the mailing of the decision by the independent contractor central unit.

(ii) At the conclusion of the mediation process, the mediator shall issue a report summarizing the status of the proceeding and shall mail a copy of the report to the parties.

(c) If after mediation the parties have not resolved their dispute concerning a worker's status as an independent contractor or an employee, a party may appeal the decision of the independent contractor central unit by filing a petition with the workers' compensation court within 30 days of the mailing of the mediator's report.

(d) An appeal from the independent contractor central unit to the workers' compensation court brought pursuant to this ~~part~~ subsection (2) is a new proceeding."

Section 4. Section 39-71-417, MCA, is amended to read:

"39-71-417. Independent contractor certification. (1) (a) 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.

(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 a sole proprietor, a working member of a partnership, a working member of a limited liability partnership, or a working member of a member-managed limited liability company.

(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) 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:

(a) the applicant's name and address;

(b) the applicant's social security number;

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

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

(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.

(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~~ department's independent contractor central unit denies an application for an independent contractor exemption certificate, the applicant may contest ~~the denial by petitioning the workers' compensation court within 30 days of the mailing of the denial~~ that decision as provided in 39-71-415(2)."

Section 5. Section 39-71-418, MCA, is amended to read:

"39-71-418. Suspension or revocation of independent contractor exemption certificate. (1) The department may suspend an independent contractor exemption certificate for a specific business relationship if the department determines that the employing unit exerts or retains a right of control to a degree that causes a certificate holder to violate the provisions of 39-71-417(4).

(2) The department may revoke an independent contractor exemption certificate after determining that the certificate holder:

(a) provided misrepresentations in the application affidavit or certificate renewal form;

(b) altered or amended the application form, the renewal application form, other supporting documentation required by the department, or the independent contractor exemption certificate; or

(c) failed to cooperate with the department in providing information relevant to the continued validity of the holder's certificate.

(3) A decision by the department to suspend or revoke an independent contractor exemption certificate takes effect upon issuance of the decision. Suspension or revocation of the independent contractor exemption certificate does not invalidate the certificate holder's waiver of the rights and benefits of the Workers' Compensation Act for the period prior to notice to the hiring agent by the department of the department's decision to suspend or revoke the independent contractor exemption certificate.

(4) A decision by the ~~department~~ department's independent contractor central unit to suspend or revoke an independent contractor exemption certificate may be ~~appealed~~ contested in the same manner as provided in ~~39-71-417(9) for denial of an application for an independent contractor exemption certificate~~ 39-71-415(2)."

Section 6. Section 39-71-704, MCA, is amended to read:

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

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

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

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

of and in the course of employment.

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

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

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

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

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

(D) travel for unauthorized treatment or disallowed procedures.

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

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

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

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

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

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

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

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

(2) The department shall annually establish a schedule of fees for medical services ~~not provided at a hospital~~ that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

~~(3) (a) The department shall establish rates for hospital services necessary for the treatment of injured workers.~~

~~(b) Except as provided in subsection (3)(g), rates for services provided at a hospital must be the greater of:~~

~~(i) 69% of the hospital's January 1, 1997, usual and customary charges; or~~

~~(ii) the discount factor established by the department that was in effect on June 30, 1997, for the hospital. The discount factor for a hospital formed by the merger of two or more existing hospitals is computed by using the weighted average of the discount factors in effect at the time of the merger.~~

~~(c) Except as provided in subsection (3)(g), the department shall adjust hospital discount factors so that the rate of payment does not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.~~

~~(d) The department may establish a fee schedule for hospital outpatient services rendered. The fee schedule must, in the aggregate, provide for fees that are equal to the statewide average discount factors paid to hospitals to provide the same or equivalent procedure to workers' compensation hospital outpatients.~~

~~(e) The discount factors established by the department pursuant to this subsection (3) may not be less than medicaid reimbursement rates.~~

~~(f)~~(3) For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

~~(g) For a medical assistance facility or a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual and customary charge. Fees paid to a licensed medical assistance facility or critical access hospital are not subject to the limitation provided in subsection (4).~~

(4) The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.

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

(6) ~~Disputes~~ After mediation pursuant to department rules, disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

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

(b) "Visit", as used in this subsection (7), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

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

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is for treatment requested by an insurer."

Section 7. Section 39-71-727, MCA, is amended to read:

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

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

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

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

unavailable.

(5) ~~Reimbursement rates payable by an insurer are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per product.~~ The department shall establish annually a schedule of fees for prescription drugs.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

~~(7) For purposes of this section, average wholesale prices must be updated weekly.~~

~~(8)~~(7) For purposes of this section, the terms "brand name"~~, "drug product",~~ and "generic name" have the ~~same meaning as~~ meanings provided in 37-7-502.

~~(9)~~(8) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy.

~~(10)~~(9) The provisions of this section do not apply to an agreement between a preferred provider organization and an insurer."

Section 8. Section 39-71-1107, MCA, is amended to read:

"39-71-1107. Domiciliary care -- requirements -- evaluation. (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a

family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing hourly wage for home health care aides, as published by the department in the edition of the Montana Informational Wage Rates by Occupation that is in effect at the time the services are rendered, and the insurer is not liable for more than 8 hours of care ~~per~~ each day."

Section 9. Section 39-71-2106, MCA, is amended to read:

"39-71-2106. Requiring security of employer. (1) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require any employer who elects to be bound by compensation plan No. 1 to provide a security deposit in accordance with rules adopted by the department. All securities of the United States treasury must be in book-entry form. The security deposit may be a surety bond, government bond, certificate of deposit, or letter of credit approved by the department and the Montana self-insurers guaranty fund. For the first 3 years of operating as a self-insured employer, the employer's security deposit must be the greater of:

(i) $250,000; or

(ii) an average of the workers' compensation liabilities incurred by the employer in Montana for the first 3 of the last 4 completed calendar years.

(b) The department, with the concurrence of the Montana self-insurers guaranty fund, may, in accordance with rules adopted by the department, require a larger deposit as additional evidence of ability to pay the benefits provided by this chapter.

(c) The department may, with the concurrence of the Montana self-insurers guaranty fund, reduce the amount of the security deposit if the evidence indicates that the full amount of the deposit is unnecessary.

(2) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require an employer to give security in addition to the security deposit described in subsection (1) if:

(i) the department, with the concurrence of the Montana self-insurers guaranty fund, determines that the employer lacks the ability to pay the benefits that are expected to be paid by the employer under the terms and conditions of this chapter that are chargeable to the employer during the year to be covered by the permission provided for in 39-71-2103; or

(ii) the employer is a group of individual employers seeking permission to operate under compensation

plan No. 1.

(b) The additional security required in subsection (2)(a) must be an amount that the department, with the concurrence of the Montana self-insurers guaranty fund, finds reasonable and necessary to pay the benefits provided under the terms and conditions of this chapter that the employer may accrue during the year.

(3) (a) The security deposit provided for in subsection (1) must be deposited with the department. The security deposit may consist of:

(i) a bond executed to the department with a surety. The security deposit must state that the employer will pay or cause to be paid to employees the amount for which the employer was given permission under 39-71-2103 and for which the employer is liable under the terms and conditions of this chapter during the year.

(ii) any Montana state, county, municipal, or school district bonds that the department and the Montana self-insurers guaranty fund consider solvent; or

(iii) other security deposits allowed in subsection (1)(a).

(b) Each security deposit and the character and amount of the security deposit are subject to approval, revision, or change considered necessary by the department and the Montana self-insurers guaranty fund.

(c) Upon proof of the final payment of the liability for which the security deposit is given, the security deposit or any remainder of the security deposit must be returned to the depositor.

(d) Payment must be made from the security deposit within 30 days of a demand by the department for payment. If payment is not made within 30 days by the obligor on the security deposit, the obligor is liable to the department for interest at the annual rate of 10% on the amount unpaid.

(4) The department is liable for the value and safekeeping of all security deposits and shall, at any time, upon demand of the depositor, account for the security deposits."

Section 10. Section 39-71-2201, MCA, is amended to read:

"39-71-2201. Election to be bound by plan -- captive reciprocal insurers. (1) Any employer except those specified in 39-71-403 may, by filing ~~his~~ an election to become bound by compensation plan No. 2, insure ~~his~~ the employer's liability to pay the compensation and benefits provided by this chapter with any insurance company authorized to transact such business in this state.

(2) Any employer electing to become bound by compensation plan No. 2 shall make ~~his~~ the election on the form and in the manner prescribed by the department.

(3) A captive reciprocal insurer established by or on behalf of an employer or a group of employers is considered to be a compensation plan No. 2 insurer."

Section 11. Section 39-71-2204, MCA, is amended to read:

"39-71-2204. Insurer to submit notice of coverage within thirty days -- penalty for failure. (1) The insurer shall, within 30 days after the issuance of ~~the~~ a policy of workers' compensation insurance, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information that may be required by the department. ~~Beginning January 1, 2006, notice~~ Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

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

(3) The department may, in its discretion, assess a penalty of ~~no~~ not more than $200 against an insurer that ~~as a general business practice~~ does not comply with the 30-day notice requirement set forth in subsection (1). The penalty may be assessed for each policy that is not reported to the department in a timely manner."

Section 12. Section 39-71-2205, MCA, is amended to read:

"39-71-2205. Policy in effect until canceled or replaced -- twenty-day notification of cancellation required -- penalty. (1) The policy remains in effect until canceled, and cancellation may take effect only by written notice to the named insured and to the department at least 20 days prior to the date of cancellation. However, the policy terminates on the effective date of a replacement or succeeding workers' compensation insurance policy issued to the insured. Nothing in this section prevents an insurer from canceling a policy of workers' compensation insurance before a replacement policy is issued to the insured. ~~Beginning January 1, 2006, notice~~ Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

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

(3) (a) The department may assess a penalty of up to $200 against an insurer that does not comply with the notice requirement in subsection (1). The penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

(b) An insurer may contest the penalty assessment in a hearing conducted according to department rules."

Section 13. Section 39-71-2337, MCA, is amended to read:

"39-71-2337. State fund to submit notice of coverage within thirty days -- penalty for failure. (1) The state fund shall, within 30 days after the issuance of an insurance policy, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information the department requires. ~~Beginning January 1, 2006, notice~~ Notice to the department under this section must be provided electronically.

(2) The department:

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

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

(3) The department may assess a penalty of ~~no~~ not more than $200 against the state fund if~~, as a general business practice,~~ the state fund does not comply with the 30-day notice requirement. The penalty may be assessed for each policy that is not reported to the department in a timely manner."

NEW SECTION. **Section 14. Claim summary and actuarial documentation for impaired insurer.** (1) An insurer becomes impaired if the insurer:

(a) becomes insolvent;

(b) is placed in receivership or administration;

(c) declares bankruptcy; or

(d) seeks protection from its creditors.

(2) An impaired insurer shall, within 30 days of the insurer becoming impaired, furnish the department with a claim summary and actuary information relevant to each claim for which the insurer may have future liability.

NEW SECTION. **Section 15. Security deposit to ensure payment of liability of plan No. 2 insurer.** (1) A plan No. 2 insurer issuing or renewing a policy on or after January 1, 2008, shall post a security deposit with the department as provided by this section. The purpose of the security deposit is to provide a ready source of

funds to pay claims arising under this chapter if the plan No. 2 insurer:

(a) becomes insolvent;

(b) is placed in receivership;

(c) declares bankruptcy;

(d) seeks protection from its creditors; or

(e) is otherwise unwilling or unable to pay its liabilities arising under this chapter.

(2) The amount of the security deposit, which is subject to the discretion of the department, must be in an amount from $25,000 to $250,000. The security deposit must be posted in the form of:

(a) a certificate of deposit;

(b) a United States treasury note; or

(c) an irrevocable letter of credit.

(3) If a plan No. 2 insurer fails to discharge any determined liability within the time set by the department, the department may convert the security deposit to cash and use the proceeds to pay the liability. Upon the conversion, the plan No. 2 insurer shall immediately furnish additional security to the department in an amount determined by the department to provide reasonable assurance that all current and future liabilities incurred by the plan No. 2 insurer as a result of the coverage provided under this chapter can be fully paid.

(4) (a) The security deposit required by this section is the property of the department and is held in trust by the department for the payment of the liabilities of the plan No. 2 insurer incurred under this chapter.

(b) Any earnings made by the security deposit accrue to the security deposit.

(c) Upon proof of final payment of all liabilities incurred under this chapter, the unexpended portion of the security deposit must be discharged and any proceeds remaining are payable to the plan No. 2 insurer.

(5) In the event of the insolvency of a plan No. 2 insurer, the department may, in its discretion, release part or all of the security deposit to the Montana insurance guaranty association, provided for in 33-10-103, for payment of the plan No. 2 insurer's Montana workers' compensation claims if:

(a) the plan No. 2 insurer has been determined to be insolvent by a court of competent jurisdiction or is the debtor in a bankruptcy proceeding;

(b) the plan No. 2 insurer is unable to pay its workers' compensation claims; and

(c) the plan No. 2 insurer's Montana workers' compensation liabilities have become the responsibility of the Montana insurance guaranty association.

(6) The department is authorized to share information and coordinate its actions with the Montana insurance commissioner and other appropriate regulatory agencies with respect to actions taken pursuant to this

section.

NEW SECTION. **Section 16. Repealer.** Section 39-71-2208, MCA, is repealed.

NEW SECTION. **Section 17. Codification instruction.** [Sections 14 and 15] 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 14 and 15].

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