HOUSE BILL 628

Introduced by Toole, et al.

2/13	Introduced
2/13	Referred to Workers' Compensation Select Committee
2/13	First Reading
2/13	Fiscal Note Requested
2/17	Hearing
2/19	Fiscal Note Received
2/20	Fiscal Note Printed
2/23	Corrected Fiscal Note Printed
3/11	Committee Report--Bill Passed as Amended and Rereferred to Labor and Employment Relations
3/16	Hearing
3/20	Committee Report--Bill Passed as Amended
3/25	2nd Reading Do Pass Motion Failed

House BILL NO. 628

INTRODUCED BY Driscoll McCulloch Waterman Ward

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; MANDATING MANAGED CARE IN CERTAIN INSTANCES; CREATING A MEDICAL PROCEDURES AUTHORIZATION COMMITTEE; PROVIDING FOR MEDICAL CARE PLANS; LIMITING FREEDOM OF CHOICE OF PRACTITIONERS; REQUIRING STATE FUND PREMIUM RATES TO BE IN ACCORDANCE WITH RATES ESTABLISHED BY THE NATIONAL COUNCIL ON COMPENSATION INSURANCE; AUTHORIZING THE STATE FUND TO DECLARE DIVIDENDS FOR CERTAIN INDUSTRY CATEGORIES; AMENDING SECTIONS 33-22-111, 39-71-608, AND 39-71-2316, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Managed care.** (1) Managed care is medical care that is subject to the planning and budgeting procedures provided for in [sections 1 through 4].

(2) Insurers operating under plans No. 1, 2, and 3 are required to use the procedures set forth in the authorized medical procedures manual provided for in [section 3] in order to control the costs of medical care while providing full medical benefits in all cases in which medical benefits are authorized.

(3) In all cases involving head injuries or multiple injuries or in cases in which a licensed physician determines within 30 days after the date of the injury that it is likely that the claimant's maximum healing condition will result in a whole-body impairment rating greater than 10%, the managed care procedures provided in [sections 1 through 4] must be followed by health care providers, claimants, and attorneys representing claimants.

NEW SECTION. **Section 2. Managed care treatment planning and budgeting.** (1) In all cases in which managed care is required, medical care plans must be established to govern the course of medical treatment for the injury. Medical care plans must establish projected treatment protocols for every case in which managed care is required to be used and must include:

(a) allowable diagnostic procedures for initial and subsequent care;

(b) allowable therapeutic modalities;

(c) allowable maintenance therapies;

(d) allowable medications; and

(e) any other anticipated therapies reasonably necessary for the case.

(2) Every medical care plan must set forth the estimated quantity, duration, and timeframe for each approved diagnostic technique, therapeutic modality,

HB 628
INTRODUCED BILL

maintenance therapy, medication, or other therapy.

(3) All medical care plans and projected treatment protocols must be based on the most recent authorized medical procedures manual developed and maintained by the medical procedures authorization committee in accordance with [section 3] and must be prepared on forms developed by the department.

(4) A budget must be established as part of each medical care plan. Each budget must provide a complete estimate of the cost of each authorized diagnostic procedure and therapeutic modality and must be adopted by the insurer after consultation with the treating physician, the claimant, and the claimant's counsel, if any.

(5) Treatment plans must provide that care is to terminate when the claimant reaches maximum healing. If in the opinion of the claimant's health care provider long-term medical care will most likely be required, the insurer is permitted to develop a modified plan for the anticipated care.

NEW SECTION. **Section 3. Medical procedures authorization committee -- creation -- membership -- responsibilities.** (1) A medical procedures authorization committee is established and shall operate under and with technical assistance from the department. The committee consists of one practitioner licensed in this state from

each of the following categories:

(a) orthopedic surgeon;

(b) chiropractor;

(c) physical therapist;

(d) neuropsychologist;

(e) occupational therapist; and

(f) dentist.

(2) The committee members must be selected by the governor. Each member shall serve a 3-year term.

(3) The committee shall develop and maintain an authorized medical procedures manual for use in developing medical care plans and budgets under [section 2]. The manual must contain a current list of diagnostic and therapeutic protocols setting forth medical conditions and authorized charges for each listed procedure.

NEW SECTION. **Section 4. Medical care plan implementation -- exceptions.** (1) In all claims in which medical care plans are used, the plan governs all care except when it clearly appears that one or more of the following circumstances exist and a modification is required:

(a) a substantial and continuing change in the medical condition or circumstances of the claimant renders one or more parts of the treatment plan inappropriate;

(b) a medical emergency necessitates a change;

(c) a health care provider change or designation is made pursuant to 33-22-111; or

(d) medical circumstances require a change in the plan currently in effect.

(2) If a plan requires modification under subsection (1), the insurer shall, unless the claim no longer meets the criteria for case management under [section 1], put in place a new medical care plan and budget following the procedures set forth in [section 2].

Section 5. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, and, except as provided in subsection (3), all policies insuring the payment of compensation under the Workers' Compensation Act ~~shall~~ must provide that the insured ~~shall--have~~ has full freedom of choice in the selection of any duly licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of ~~his~~ the person's practice. Whenever ~~such~~ policies insure against the expense of drugs, the

insured ~~shall~~ must have full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing--in--this~~ This section ~~shall~~ may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1)~~;~~. ~~nor--shall--this~~ This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

(3) If a workers' compensation claimant is subject to the managed care requirements of [section 2], the freedom of choice provided in subsection (1) does not apply in the following instances:

(a) the claimant obtains services from more than one health care provider without a referral from the claimant's initial treating physician;

(b) the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide satisfactory therapy for the claimant's injuries;

(c) the claimant seeks to change or add health care providers without the insurer's authorization; or

(d) the insurer determines, during the course of treatment, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the

claimant's recovery or therapy.

(4) In any of the situations listed in subsection (3), the insurer, after giving notice to the claimant and allowing the claimant 10 days in which to contact and discuss the matter with the insurer, the treating physician, or the claimant's attorney, is authorized to designate all health care providers, including the treating physician."

Section 6. Section 39-71-608, MCA, is amended to read:

"**39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice.** An insurer may, after written notice to the claimant and the department, make payment of compensation benefits, including managed medical care benefits, within 30 days of receipt of a claim for compensation without such the payments being construed as an admission of liability or a waiver of any right of defense. Managed care provisions under [section 2] must apply at the election of the insurer, without obligating the insurer or claimant to continue managed care in the event that liability or coverage is otherwise denied."

Section 7. Section 39-71-2316, MCA, is amended to read:

"**39-71-2316. Powers of the state fund -- rulemaking.** For the purposes of carrying out its functions, the state fund may:

(1) insure any employer for workers' compensation and

occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance. The state fund may charge a minimum yearly premium to cover its administrative costs for coverage of a small employer.

(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 21, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

(6) adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may only be adopted and changed using a process, a procedure, formulas, and factors set forth in rules adopted under Title 2, chapter 4, parts 2 through 4. After such rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate. The state fund must belong to the national council on

compensation insurance and shall use the classifications of employment adopted by the national council and corresponding rates as a basis for setting its own rates.

(7) pay the amounts determined due under a policy of insurance issued by the state fund;

(8) hire personnel;

(9) declare dividends ~~if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside. If those reserves have been set aside, money that can be declared as a dividend must be transferred to the account created by 39-71-2321 for claims for injuries resulting from accidents that occurred before July 1, 1990, and used for the purposes of that account. After all claims funded by that account have been paid, dividends may be declared and paid to insureds~~ as provided in this subsection. After establishing rates for all covered employments in accordance with the rates of the national council on compensation insurance, if it is actuarially determined that in-state experience ratings within certain industry categories justify a reduction of rates for those categories and that rate-reduction dividends may be declared based upon the experience ratings for those industries without impairing the ability of the state fund to meet its obligations or to ensure that assets will exceed liabilities, then the state

fund is authorized to declare appropriate dividends for those industries.

(10) perform all functions and exercise all powers of a domestic mutual insurer that are necessary, appropriate, or convenient for the administration of the state fund."

NEW SECTION. **Section 8.** **Codification instruction.** [Sections 1 through 4] 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 4].

NEW SECTION. **Section 9.** **Effective date.** [This act] is effective on passage and approval.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for HB0628, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:
An act generally revising workers' compensation laws; mandating managed care in certain instances; creating a medical procedures authorization committee; providing for medical care plans; limiting freedom of choice of practitioners; requiring State Fund premium rates to be in accordance with rates established by the National Council on Compensation Insurance; authorizing the State Fund to declare dividends for certain industry categories.

ASSUMPTIONS:
Department of Labor and Industry:
1. 1.00 FTE mediator (grade 16) would be required to meet the additional mediation workload created by the proposed legislation's section (Bill Section 5) 32-22-111.
2. 1.00 FTE program officer (grade 14) for ERD's Policy Compliance Unit to meet the increased workload created by the proposed legislation's new Section 3 and to work with the Medical Procedures Authorization Committee to establish the procedures manual and to maintain the manual after it is developed.
3. Costs would be funded from assessments to workers' compensation carriers.

State Compensation Mutual Insurance Fund:
1. In order to determine the fiscal impact to the State Fund as a result of this bill an actuarial study would be necessary; however, due to the time constraints a study cannot be accomplished for the fiscal note.
2. A portion of the costs incurred by the Department of Labor and Industry would be assessed to the State Fund. Approximately 50% of costs would be assessed under the mediation category (State Fund share = 70%); 50% of costs would assessed under the medical regulation category (State Fund share = 65%).

(continued)

Dave Lewis 2-19-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

HOWARD TOOLE, PRIMARY SPONSOR DATE

FISCAL IMPACT:

Expenditures:

DLI Employment Relations Div. (Pg 04):

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	60.55	62.55	2.00	60.55	62.55	2.00
Personal Services	1,813,414	1,888,530	70,116	1,817,143	1,888,219	71,076
Operating Expenses	943,410	981,689	38,279	926,413	961,592	35,179
Equipment	87,020	96,020	9,000	87,020	87,020	0
Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
Total	4,472,671	4,590,066	117,395	4,600,403	4,706,658	106,255
Funding:						
General Fund	348,118	348,118	0	319,589	319,589	0
State Special Revenue	1,723,306	1,840,701	117,395	1,722,779	1,829,034	106,255
Federal Revenue	635,365	635,365	0	632,662	632,662	0
Proprietary Revenue	1,765,882	1,765,882	0	1,925,373	1,925,373	0
Total	4,472,671	4,590,066	117,395	4,600,403	4,706,658	106,255
Revenues:						
WC Assessments (02)	3,197,368	3,314,763	117,395	3,199,373	3,305,628	106,255

State Compensation Mutual Insurance Fund:

Expenditures:
The proposed legislation may result in some level of savings in workers' compensation medical benefits for the State Fund. Workers' compensation assessments would increase by approximately $79,200 in FY94 and $71,700 in FY95.

Revenues:
The proposed legislation would result in a major increase in premium revenue. The increase would be unlikely to be refunded to policyholders for several years until the financial performance for a policy period was determined.

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
Local governments which self-insure for workers' compensation coverage would incur additional workers' compensation assessments from the Department of Labor.

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(continued)

Dave Lewis 2-19-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

2/20/93
HOWARD TOOLE, PRIMARY SPONSOR DATE

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Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
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DAVID LEWIS, BUDGET DIRECTOR DATE
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Howard Toole 2/23/93
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HB628-4

Approved by the Select committee on workers' compensation.

RE-REFERRED AND
APPROVED BY COMMITTEE
ON LABOR & EMPLOYMENT
RELATIONS

HOUSE BILL NO. 628

INTRODUCED BY TOOLE, DRISCOLL, MCCULLOCH,

WANZENRIED, HIBBARD

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; MANDATING MANAGED CARE IN CERTAIN INSTANCES; CREATING A MEDICAL PROCEDURES AUTHORIZATION COMMITTEE; PROVIDING FOR MEDICAL CARE PLANS; LIMITING FREEDOM OF CHOICE OF PRACTITIONERS; REQUIRING STATE FUND PREMIUM RATES TO BE IN ACCORDANCE WITH RATES ESTABLISHED BY THE NATIONAL COUNCIL ON COMPENSATION INSURANCE; AUTHORIZING THE STATE FUND TO DECLARE DIVIDENDS FOR CERTAIN INDUSTRY CATEGORIES; AMENDING SECTIONS 33-22-111, 39-71-608, AND 39-71-2316, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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(3) In all cases involving head injuries or multiple injuries or in cases in which a licensed physician determines within 30 days after the date of the injury that it is likely that the claimant's maximum healing condition will result in a whole-body impairment rating greater than 10%, the managed care procedures provided in [sections 1 through 4] must be followed by health care providers, claimants, and attorneys representing claimants.

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(4) A budget must be established as part of each medical care plan. Each budget must provide a complete estimate of the cost of each authorized diagnostic procedure and therapeutic modality and must be adopted by the insurer after consultation with the treating physician, the claimant, and the claimant's counsel, if any.

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(a) orthopedic surgeon;

(b) chiropractor;

(c) physical therapist;

(d) neuropsychologist;

(e) occupational therapist; and

(f) dentist.

(2) The committee members must be selected by the governor. Each member shall serve a 3-year term.

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(b) the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide satisfactory therapy for the claimant's injuries;

(c) the claimant seeks to change or add health care providers without the insurer's authorization; or

(d) ~~the--insurer--determines;--during--the--course---of~~ treatment THE DEPARTMENT DETERMINES, UPON APPLICATION BY THE INSURER OR THE CLAIMANT AND FOLLOWING CONSULTATION WITH THE

INSURER, THE CLAIMANT, OR THE CLAIMANT'S ATTORNEY, AND THE TREATING PHYSICIAN, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the claimant's recovery or therapy.

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(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 21, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

(6) adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may only be adopted and changed using a process, a procedure, formulas, and factors set forth in rules adopted under Title 2, chapter 4, parts 2 through 4. After ~~such~~ rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when

changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate. The state fund must belong to the national council on compensation insurance and shall use the classifications of employment adopted by the national council and corresponding rates as a basis for setting its own rates.

(7) pay the amounts determined due under a policy of insurance issued by the state fund;

(8) hire personnel;

(9) declare dividends ~~if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside. If those reserves have been set aside, money that can be declared as a dividend must be transferred to the account created by 39-71-2321 for claims for injuries resulting from accidents that occurred before July 1, 1990, and used for the purposes of that account. After all claims funded by that account have been paid, dividends may be declared and paid to insureds~~ as provided in this subsection. After establishing rates for all covered employments in accordance with the rates of the national council on compensation insurance, if it is actuarially determined that in-state experience ratings within certain industry categories justify a reduction of rates for those categories and that

rate-reduction dividends may be declared based upon the experience ratings for those industries without impairing the ability of the state fund to meet its obligations or to ensure that assets will exceed liabilities, then the state fund is authorized to declare appropriate dividends for those industries.

(10) perform all functions and exercise all powers of a domestic mutual insurer that are necessary, appropriate, or convenient for the administration of the state fund."

NEW SECTION. **Section 8.** **Codification instruction.** [Sections 1 through 4] 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 4].

NEW SECTION. **Section 9.** **Effective date.** [This act] is effective on passage and approval.

-End-

RE-REFERRED AND APPROVED BY COMMITTEE ON LABOR & EMPLOYMENT RELATIONS AS AMENDED

HB 0628/03

HOUSE BILL NO. 628

INTRODUCED BY TOOLE, DRISCOLL, MCCULLOCH, WANZENRIED, HIBBARD

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; MANDATING ~~MANAGED~~ CARE MANAGEMENT AND BUDGETING IN CERTAIN INSTANCES; CREATING A MEDICAL PROCEDURES AUTHORIZATION COMMITTEE; PROVIDING FOR ~~MEDICAL~~ CARE PLANS; ~~LIMITING---FREEDOM--OF--CHOICE--OF PRACTITIONERS;-REQUIRING-STATE-FUND-PREMIUM-RATES-TO--BE--IN ACCORDANCE-WITH-RATES-ESTABLISHED-BY-THE-NATIONAL-COUNCIL-ON COMPENSATION---INSURANCE;--AUTHORIZING--THE--STATE--FUND--TO DECLARE-DIVIDENDS-FOR-CERTAIN-INDUSTRY-CATEGORIES;~~ AMENDING ~~SECTIONS~~ SECTION ~~33-22-111;~~ 39-71-608, ~~AND-39-71-2316;~~ MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

NEW SECTION. **Section 1.** ~~"Managed care." (1) Managed care is--medical--care--that--is--subject--to--the--planning--and budgeting-procedures-provided-for-in-[sections-1-through-4];~~

~~(2)--Insurers~~ CARE MANAGEMENT AND BUDGETING. (1) THE STATE FUND operating under ~~plans-No.-1,-2,-and~~ PLAN NO. 3 ~~are~~ IS required to use the procedures set forth in the authorized medical procedures manual provided for in [section 3] in order to control the costs of medical care while providing full medical benefits in all cases in which medical benefits are authorized.

~~(3)~~(2) In ~~all-cases-involving-head-injuries-or-multiple injuries--or--in~~ cases in which a licensed physician determines within 30 days after the date of the injury that it is MORE likely THAN NOT that the claimant's maximum healing condition will result in a whole-body impairment rating greater than 10%, the ~~managed~~ care MANAGEMENT AND BUDGETING procedures provided in [sections 1 through 4] must be followed by health care providers, claimants, and attorneys representing claimants.

NEW SECTION. **Section 2.** ~~"Managed care" treatment~~ CARE MANAGEMENT ~~planning~~ and budgeting. (1) In all cases in which ~~managed~~ care MANAGEMENT AND BUDGETING is required, ~~medical~~ care plans must be established to govern the course of medical treatment for the injury. ~~Medical--care~~ CARE plans must establish projected treatment protocols for every case in which ~~managed-care-is~~ THEY ARE required ~~to--be--used~~ and must include:

(a) allowable diagnostic procedures for initial and subsequent care;

(b) allowable therapeutic modalities;

(c) allowable maintenance therapies;

(d) allowable medications; and

(e) any other anticipated therapies reasonably

necessary for the case.

(2) Every ~~medical~~ care plan must set forth the estimated quantity, duration, and timeframe for each approved diagnostic technique, therapeutic modality, maintenance therapy, medication, or other therapy.

(3) All ~~medical~~ care plans and projected treatment protocols must be based on the most recent authorized medical procedures manual developed and maintained by the medical procedures authorization committee in accordance with [section 3] and must be prepared on forms developed by the department.

(4) A budget must be established as part of each ~~medical~~ care plan. Each budget must provide a complete estimate of the cost of each authorized diagnostic procedure and therapeutic modality and must be adopted by the insurer after consultation with the treating physician, the claimant, and the claimant's counsel, if any.

(5) ~~Treatment~~ CARE plans must provide that care is to terminate when the claimant reaches maximum healing. If in the opinion of the claimant's health care provider long-term medical care will most likely be required, the insurer is permitted to develop a modified plan for the anticipated care.

NEW SECTION. **Section 3. Medical procedures authorization committee -- creation -- membership --**

responsibilities. (1) A medical procedures authorization committee is established and shall operate under and with technical assistance from the department. The committee consists of one practitioner licensed in this state from each of the following categories:

(a) orthopedic surgeon;

(b) chiropractor;

(c) physical therapist;

(d) neuropsychologist;

(e) occupational therapist; and

(f) dentist.

(2) The committee members must be selected by the governor. Each member shall serve a 3-year term.

(3) The committee shall develop and maintain an authorized medical procedures manual for use in developing ~~medical~~ care plans and budgets under [section 2]. The manual must contain a current list of diagnostic and therapeutic protocols setting forth medical conditions and authorized charges AS SET FORTH IN DIAGNOSTIC RESEARCH GROUPS for each listed procedure. THESE CHARGES MAY NOT EXCEED THOSE CURRENTLY CONTAINED IN THE MEDICAL FEE SCHEDULE AUTHORIZED IN 39-71-704.

NEW SECTION. **Section 4. ~~Medical~~ care CARE plan implementation -- exceptions.** (1) In all claims in which ~~medical~~ care plans are used, the plan governs all care

except when it clearly appears that one or more of the following circumstances exist and a modification is required:

(a) a substantial and continuing change in the medical condition or circumstances of the claimant renders one or more parts of the treatment plan inappropriate;

(b) a medical emergency necessitates a change;

(c) a health care provider change or designation is made pursuant to 33-22-111; or

(d) medical circumstances require a change in the plan currently in effect.

(2) If a plan requires modification under subsection (1), the insurer shall, unless the claim no longer meets the criteria for case management under [section 1], put in place a new ~~medical~~ care plan and budget following the procedures set forth in [section 2].

~~Section 5.~~ ~~--Section 33-22-111, MCA, is amended to read:--~~

~~"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, and, except as provided in subsection (3), all policies insuring the payment of compensation under the Workers' Compensation Act shall must provide that the insured shall have has full freedom of choice in the selection of any duly licensed physician, physician assistant certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his the person's practice. Whenever such policies insure against the expense of drugs, the insured shall must have full freedom of choice in the selection of any duly licensed and registered pharmacist.~~

~~(2) Nothing in this This section shall may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1), nor shall this This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.~~

~~(3) If a workers' compensation claimant is subject to the managed care requirements of [section 2], the freedom of choice provided in subsection (1) does not apply in the following instances:~~

~~(a) the claimant obtains services from more than one health care provider without a referral from the claimant's initial treating physician;~~

~~(b) the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide~~

satisfactory therapy for the claimant's injuries;

(c) the claimant seeks to change or add health care providers without the insurer's authorization; or

(d) the insurer determines, during the course of treatment THE DEPARTMENT DETERMINES, UPON APPLICATION BY THE INSURER OR THE CLAIMANT AND FOLLOWING CONSULTATION WITH THE INSURER, THE CLAIMANT, OR THE CLAIMANT'S ATTORNEY, AND THE TREATING PHYSICIAN, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the claimant's recovery or therapy.

(4) In any of the situations listed in subsection (3), the insurer DEPARTMENT, after giving notice to the claimant and allowing the claimant 10 days in which to contact and discuss the matter with the insurer, the treating physician, or the claimant's attorney, is authorized to designate all health care providers, including the treating physician."

Section 5. Section 39-71-608, MCA, is amended to read:

"39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice. An insurer may, after written notice to the claimant and the department, make payment of compensation benefits, including managed medical care benefits UNDER CARE MANAGEMENT AND BUDGETING, within 30 days of receipt of a claim for compensation without such the

payments being construed as an admission of liability or a waiver of any right of defense. Managed care CARE MANAGEMENT AND BUDGETING provisions under [section 2] must apply at the election of the insurer, without obligating the insurer or claimant to continue managed care MANAGEMENT AND BUDGETING in the event that liability or coverage is otherwise denied."

Section 7. Section 39-71-2316, MCA, is amended to read:

"39-71-2316. Powers of the state fund -- rulemaking. For the purposes of carrying out its functions, the state fund may:

(1) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance. The state fund may charge a minimum yearly premium to cover its administrative costs for coverage of a small employer;

(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 21, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

~~(6)--adopt-classifications-and-charge-premiums--for--the classifications--so-that-the-state-fund-will-be-neither-more nor---less---than---self-supporting.----Premium---rates---for classifications-may-only-be--adopted--and--changed--using--a process,--a--procedure,--formulas,--and-factors-set-forth-in rules-adopted-under-Title-2,-chapter-4,-parts-2--through--4. After--such-rules-have-been-adopted,-the-state-fund-need-not follow-the-rulemaking-provisions-of-Title-2,-chapter-4,-when changing-classifications-and-premium--rates.--The--contested case--rights--and--provisions--of-Title-2,-chapter-4,-do-not apply-to-an-employer's-classification-or-premium--rate.--The state---fund---must---belong--to--the--national--council--on compensation-insurance-and-shall-use-the-classifications--of employment-adopted-by-the-national-council-and-corresponding rates-as-a-basis-for-setting-its-own-rates.~~

~~(7)--pay--the--amounts--determined-due-under-a-policy-of insurance-issued-by-the-state-fund;~~

~~(8)--hire-personnel;~~

~~(9)--declare-dividends-if-there-is-an-excess--of--assets over--liabilities.--However,-dividends-may-not-be-paid-until adequate-actuarially-determined-reserves-are-set--aside.--If those--reserves--have--been--set--aside,--money--that-can-be declared-as-a-dividend-must-be-transferred--to--the--account created-by-39-71-2321-for-claims-for-injuries-resulting-from accidents--that--occurred--before-July-1,-1990,-and-used-for~~

~~the-purposes-of-that-account.-After--all--claims--funded--by that--account--have-been-paid,-dividends-may-be-declared-and paid-to-insureds~~ as--provided--in--this--subsection. After establishing-rates-for-all-covered-employments-in-accordance with--the--rates--of--the--national--council-on-compensation insurance,-if-it-is--actuarially--determined--that--in-state experience---ratings---within--certain--industry--categories justify-a-reduction-of-rates-for-those-categories--and--that rate-reduction--dividends--may--be--declared--based-upon-the experience-ratings-for-those--industries--without--impairing the--ability-of-the-state-fund-to-meet-its-obligations-or-to ensure-that-assets-will-exceed-liabilities,-then--the--state fund--is--authorized--to--declare--appropriate-dividends-for those-industries.

~~(10)-perform-all-functions-and-exercise-all-powers-of--a domestic--mutual-insurer-that-are-necessary,-appropriate,-or convenient-for-the-administration-of-the-state-fund.~~"

NEW SECTION. **Section 6.** Codification instruction. [Sections 1 through 4] 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 4].

NEW SECTION. **Section 7.** Effective date. [This act] is effective on passage and approval.

-End-