**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act simplifying and clarifying terminology and procedures in the Workers' Compensation Act; specifying that statutory and common-law rules of evidence are not applicable at department hearings under Title 39, Chapter 71; clarifying with whom and by whom reports of accidents, injuries, and occupational disease are to be filed; providing the department with rulemaking authority for reporting requirements for injury or occupational disease; clarifying who pays benefits when there is a dispute between insurers; clarifying how lump-sum payments are addressed; repealing statutes on payroll computation and wage definitions covered by other statutes; removing the requirement for assessments on certain public corporations that fail to file payroll reports; amending sections 39-71-105, 39-71-107, 39-71-201, 39-71-204, 39-71-307, 39-71-407, 39-71-608, 39-71-703, 39-71-741, and 39-71-1006, MCA; repealing sections 39-71-302, 39-71-303, 39-71-308, and 39-71-318, MCA; and providing an effective date and an applicability date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, chapters 71 and 72, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault, ~~wage supplement~~ 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; they are intended to assist 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) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) 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.

(4) Title 39, chapters 71 and 72, must be construed

according to their terms and not liberally in favor of any party.

(5) It is the intent of the legislature that 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, ~~as is the case with repetitive injury claims,~~ and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system."

{*Internal References to 39-71-105:*
a39-71-107 }

Section 2. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims -- in-state adjusters. (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 and the Occupational Disease Act of Montana must be adjusted by a person in Montana. For a claim to be considered as adjusted by a person in Montana, the person adjusting 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 adjust 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 and the Occupational Disease Act of Montana at the Montana office of the person adjusting 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 adjuster's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) 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) 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) An insurer may not make payments pursuant to 39-71-608 or any other reservation of rights for more than 90 days without:~~

~~(a) written consent of the claimant; or~~

~~(b) approval of the department.~~

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

~~(8)~~(7) 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. The term does not include a claim in which there has been only a lump-sum advance of benefits."

{*Internal References to 39-71-107: None.*}

Section 3. 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 all

costs of administering the Workers' Compensation and Occupational Disease Acts and the statutory occupational safety acts the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund, are to be paid upon lawful appropriation. 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 39-71-205, 39-71-223, 39-71-304, 39-71-307, ~~39-71-308,~~ 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 and the Occupational Disease Act of Montana 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 Occupational Disease Act of Montana and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund. 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, 2001, and on each succeeding April 30, 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, 2001, and on each succeeding April 30, 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 money 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 and the Occupational Disease Act of Montana. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

{*Internal References to 39-71-201:*
x39-71-306 *x39-71-401* *x39-71-435* }

Section 4. Section 39-71-204, MCA, is amended to read:

"39-71-204. ~~Rescission~~ Hearings -- rules of evidence -- appeal, rescission, alteration, or amendment by department of its orders, decisions, or awards -- effect -- appeal. (1) The statutory and common-law rules of evidence do not apply to a hearing before the department under this chapter. A petition for a hearing before the department must be filed within 2 years after benefits are denied.

(2) A hearing under this chapter may be conducted by telephone or by videoconference.

~~(1)~~(3) The department has continuing jurisdiction over all

its orders, decisions, and awards and may, at any time, upon notice, and after opportunity to be heard is given to the parties in interest, rescind, alter, or amend any such order, decision, or award made by it upon good cause appearing therefor.

~~(2)~~ (4) Any order, decision, or award rescinding, altering, or amending a prior order, decision, or award has the same effect as original orders or awards.

~~(3)~~ (5) If a party is aggrieved by a department order, the party may appeal the dispute to the workers' compensation judge."

{*Internal References to 39-71-204: None.*}

Section 5. Section 39-71-307, MCA, is amended to read:

"39-71-307. Employers and insurers to file reports of accidents -- penalty. (1) Every employer ~~and every insurer~~ is required to file with the ~~department~~ employer's insurer, under rules adopted by the department ~~rules~~, a full and complete report of every accident, injury, or occupational disease to an employee arising out of or in the course of employment ~~and resulting in loss of life or injury to the employee. The reports must be furnished to the department in the form and detail as the department prescribes and must provide specific answers to all questions required by the department under its rules. However, if an employer is unable to answer a question, the employer shall state the reason for the employer's inability to answer.~~

(2) Every insurer transacting business under this chapter shall, ~~at the time and in the manner prescribed~~ under rules adopted by the department, make and file with the department ~~the~~

reports of ~~accidents as the department requires~~ every injury or occupational disease.

(3) An employer~~,~~ or insurer~~, or adjuster~~ who refuses or neglects to submit ~~to~~ the ~~department~~ 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."

{ *Internal References to 39-71-307:*
x39-71-201 *x50-71-325* }

Section 6. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) 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 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) (a) An insurer is liable for an injury, as defined in 39-71-119, 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 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.

(3) (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.

(4) 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. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) When benefits are payable for an injury and a dispute exists between insurers and the only dispute is which insurer is liable for the benefits, the latest insurer shall pay benefits

until that insurer establishes that it is not liable for the benefits. If the latest insurer establishes that an earlier insurer is liable for the benefits, the latest insurer must be indemnified for benefits paid during the dispute.

~~(5)~~ (6) 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.

~~(6)~~ (7) 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.

~~(7)~~ (8) 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."

{ *Internal References to 39-71-407:*
x39-71-510 }

Section 7. 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 -- limitations on payments over 90 days. (1) An insurer may, after written notice to the claimant and the department, make payment of compensation benefits within 30 days of receipt of a claim for compensation without such payments being construed as

an admission of liability or a waiver of any right of defense.

(2) An insurer may not make payments pursuant to this section for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department."

{*Internal References to 39-71-608:*
a39-71-107 *x39-71-606* *x39-71-609* *x39-71-615* }

Section 8. Section 39-71-703, MCA, is amended to read:

"39-71-703. Compensation for permanent partial disability. (1) If an injured worker suffers a permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the worker is entitled to a permanent partial disability award if that worker:

(a) has an actual wage loss as a result of the injury; and

(b) has a permanent impairment rating that:

(i) is not based exclusively on complaints of pain;

(ii) is established by objective medical findings; and

(iii) is more than zero as determined by the latest edition of the American medical association Guides to the Evaluation of Permanent Impairment.

(2) When a worker receives an impairment rating as the result of a compensable injury and has no actual wage loss as a result of the injury, the worker is eligible for an impairment award only.

(3) Beginning July 1, 2003, the permanent partial disability award must be arrived at by multiplying the percentage

arrived at through the calculation provided in subsection (5) by 375 weeks.

(4) A permanent partial disability award granted an injured worker may not exceed a permanent partial disability rating of 100%.

(5) The percentage to be used in subsection (4) must be determined by adding all of the following applicable percentages to the impairment rating:

(a) if the claimant is 40 years of age or younger at the time of injury, 0%; if the claimant is over 40 years of age at the time of injury, 1%;

(b) for a worker who has completed less than 12 years of education, 1%; for a worker who has completed 12 years or more of education or who has received a graduate equivalency diploma, 0%;

(c) if a worker has no actual wage loss as a result of the industrial injury, 0%; if a worker has an actual wage loss of $2 or less an hour as a result of the industrial injury, 10%; if a worker has an actual wage loss of more than $2 an hour as a result of the industrial injury, 20%. Wage loss benefits must be based on the difference between the actual wages received at the time of injury and the wages that the worker earns or is qualified to earn after the worker reaches maximum healing.

(d) if a worker, at the time of the injury, was performing heavy labor activity and after the injury the worker can perform only light or sedentary labor activity, 5%; if a worker, at the time of injury, was performing heavy labor activity and after the injury the worker can perform only medium labor activity, 3%; if

a worker was performing medium labor activity at the time of the injury and after the injury the worker can perform only light or sedentary labor activity, 2%.

(6) The weekly benefit rate for permanent partial disability is 66 2/3% of the wages received at the time of injury, but the rate may not exceed one-half the state's average weekly wage. The weekly benefit amount established for an injured worker may not be changed by a subsequent adjustment in the state's average weekly wage for future fiscal years.

(7) An impairment rating may be paid biweekly or in a lump sum at the discretion of the worker. Lump sums paid for an impairment rating are not subject to the requirements of 39-71-741, except that lump-sum conversions for benefits not accrued may be reduced to present value at the rate established by the department pursuant to 39-71-741(3).

~~(7)~~ (8) If a worker suffers a subsequent compensable injury or injuries to the same part of the body, the award payable for the subsequent injury may not duplicate any amounts paid for the previous injury or injuries.

~~(8)~~ (9) If a worker is eligible for a rehabilitation plan, permanent partial disability benefits payable under this section must be calculated based on the wages that the worker earns or would be qualified to earn following the completion of the rehabilitation plan.

~~(9)~~ (10) As used in this section:

(a) "heavy labor activity" means the ability to lift over 50 pounds occasionally or up to 50 pounds frequently;

(b) "medium labor activity" means the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently;

(c) "light labor activity" means the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently; and

(d) "sedentary labor activity" means the ability to lift up to 10 pounds occasionally or up to 5 pounds frequently."

{*Internal References to 39-71-703:*
x39-71-118 *x39-71-708* *x39-71-712* *a39-71-741*
x39-71-807 }

Section 9. Section 39-71-741, MCA, is amended to read:

"39-71-741. Compromise settlements and lump-sum payments. (1) By written agreement ~~filed with the department~~, benefits under this chapter may be converted in whole or in part into a lump sum. An agreement that settles a claim for any type of benefit is subject to department approval. Lump-sum advances and payment of accrued benefits in a lump sum, except permanent total disability benefits under subsection (1)(c), are not subject to department approval. If the department fails to approve or disapprove the agreement in writing within 14 days of the filing with the department, the agreement is approved. The department shall directly notify a claimant of a department order approving or disapproving a claimant's compromise or lump-sum payment. Upon approval, the agreement constitutes a compromise and release settlement and may not be reopened by the department. The department may approve an agreement to convert the following benefits to a lump sum only under the following conditions:

(a) all benefits if a claimant and an insurer dispute the

initial compensability of an injury and there is a reasonable dispute over compensability;

(b) permanent partial disability benefits if an insurer has accepted initial liability for an injury. The total of any permanent partial lump-sum conversion in part that is awarded to a claimant prior to the claimant's final award may not exceed the anticipated award under 39-71-703. The department may disapprove an agreement under this subsection (1)(b) only if the department determines that the lump-sum conversion amount is inadequate.

(c) permanent total disability benefits if the total of all lump-sum conversions in part that are awarded to a claimant do not exceed $20,000. The approval or award of a lump-sum permanent total disability payment in whole or in part by the department or court must be the exception. It may be given only if the worker has demonstrated financial need that:

(i) relates to:

(A) the necessities of life;

(B) an accumulation of debt incurred prior to the injury; or

(C) a self-employment venture that is considered feasible under criteria set forth by the department; or

(ii) arises subsequent to the date of injury or arises because of reduced income as a result of the injury; ~~or~~

(d) except as otherwise provided in this chapter, all other compromise settlements and lump-sum payments agreed to by a claimant and insurer~~.~~; or

(e) medical benefits on an accepted claim if a claimant and

an insurer dispute the insurer's continued liability for medical benefits and there is a reasonable dispute over the medical compensability.

(2) Any lump-sum conversion of benefits under this section must be converted to present value using the rate prescribed under subsection (3)(b).

(3) (a) An insurer may recoup any lump-sum payment amortized at the rate established by the department, prorated biweekly over the projected duration of the compensation period.

(b) The rate adopted by the department must be based on the average rate for United States 10-year treasury bills in the previous calendar year.

(c) If the projected compensation period is the claimant's lifetime, the life expectancy must be determined by using the most recent table of life expectancy as published by the United States national center for health statistics.

(4) A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump-sum is considered a dispute for which a mediator and the workers' compensation court have jurisdiction to make a determination. If an insurer and a claimant agree to a compromise and release settlement or a lump-sum payment but the department disapproves the agreement, the parties may request the workers' compensation court to review the department's decision."

{*Internal References to 39-71-741:*
x39-71-519 *x39-71-721* *a39-71-1006* }

Section 10. Section 39-71-1006, MCA, is amended to read:

"39-71-1006. Rehabilitation benefits. (1) A worker is eligible for rehabilitation benefits if:

(a) (i) the worker meets the definition of a disabled worker as provided in 39-71-1011; or

(ii) the worker has, as a result of the work-related injury, a whole person impairment rating of 15% or greater, as established by objective medical findings, and has no actual wage loss;

(b) a rehabilitation provider, as designated by the insurer, certifies that the worker has reasonable vocational goals and reasonable reemployment opportunity. If eligible because of an impairment rating of 15% or more, with rehabilitation the worker will have a reasonable increase in the worker's wage compared to the wage that the worker received at the time of injury. If eligible because of a wage loss, the worker will have a reasonable reduction in the worker's actual wage loss with rehabilitation.

(c) a rehabilitation plan is agreed upon by the worker and the insurer and a written copy of the plan is provided to the worker. The plan must take into consideration the worker's age, education, training, work history, residual physical capacities, and vocational interests. The plan must specify a beginning date and a completion date. The plan must specify the cost of tuition, fees, books, and other reasonable and necessary retraining expenses required to complete the plan.

(2) A disabled worker is entitled to receive biweekly

~~compensation~~ rehabilitation benefits at the worker's temporary total disability rate. The benefits must be paid for the period specified in the rehabilitation plan, not to exceed 104 weeks. The rehabilitation plan must be completed within 26 weeks of the completion date specified in the plan. Rehabilitation benefits must be paid biweekly while the worker is satisfactorily progressing in the agreed-upon rehabilitation plan. ~~Benefits~~ Rehabilitation benefits payable pursuant to a retraining rehabilitation plan under this section are not ~~subject to the lump-sum provisions of 39-71-741~~ payable in a lump sum. Rehabilitation benefits may be paid in a lump sum for job placement services or if there is a reasonable dispute over rehabilitation benefit entitlement.

(3) In addition to rehabilitation benefits payable under subsection (2), a disabled worker who was injured on or after July 1, 1997, is entitled to receive payment for tuition, fees, books, and other reasonable and necessary retraining expenses, excluding travel and living expenses paid pursuant to the provisions of 39-71-1025, as set forth in department rules and as specified in the rehabilitation plan. Expenses must be paid directly by the insurer.

(4) A worker may not receive temporary total benefits and the benefits under subsection (2) during the same period of time.

(5) A rehabilitation provider authorized by the insurer shall continue to assist the injured worker until the rehabilitation plan is completed.

(6) To be eligible for benefits under this section, a

worker is required to begin the rehabilitation plan within 78 weeks of reaching maximum medical healing.

(7) A worker may not receive both wages and rehabilitation benefits without the written consent of the insurer. A worker who receives both wages and rehabilitation benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301."

{*Internal References to 39-71-1006: 39-71-1011* }

NEW SECTION. **Section 11. {standard} Repealer.** Sections 39-71-302, 39-71-303, 39-71-308, and 39-71-318, MCA, are repealed.

{*Internal References to 39-71-302: None.*
Internal References to 39-71-303: None.
Internal References to 39-71-308: a39-71-201.
Internal References to 39-71-318: None.}

NEW SECTION. **Section 12. {standard} Effective date -- applicability.** [This act] is effective July 1, 2005, and applies to injuries occurring or occupational diseases contracted on or after July 1, 2005.

- END -

{Name : Eddye McClure
Title : Staff Attorney
Agency: Legislative Services Division
Phone : 444-3804
E-Mail: emcclure@mt.gov}