AN ACT CLARIFYING THAT ISSUERS OF HEALTH INSURANCE COVERAGE MAY NOT DENY ROUTINE PATIENT COSTS FOR INDIVIDUALS IN AN APPROVED CLINICAL TRIAL; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-704, 33-22-101, 33-31-111, 33-35-306, 53-4-1005, AND 53-6-101, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A TERMINATION DATE.

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

Section 1. Coverage of routine patient costs for participants in cancer clinical trials -- definitions -- limitations. (1) A plan of group or individual health insurance coverage that is delivered, issued for delivery, renewed, extended, or modified in this state may not:

(a) deny participation by a qualified individual in an approved clinical trial;

(b) deny, limit, or impose additional conditions on the coverage of routine patient costs; or

(c) discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

(2) A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

(3) This section applies to a qualified individual who participates in an approved clinical trial that is conducted outside of Montana.

(4) This section does not require a health insurance issuer offering individual or group health insurance coverage to provide benefits for routine patient costs if the services are provided outside of the network plan offered by the health insurance coverage unless out-of-network benefits are otherwise provided under the coverage.

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

(a) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer and is not designed exclusively to test toxicity or

disease pathophysiology. The trial must be:

(i) conducted under an investigational new drug application reviewed by the United States food and drug administration;

(ii) exempt from obtaining an investigational new drug application; or

(iii) approved or funded by:

(A) the national institutes of health, the centers for disease control and prevention, the agency for healthcare research and quality, the centers for medicare and medicaid services, or a cooperative group or center of any of the entities described in this subsection (5)(a)(iii)(A);

(B) a cooperative group or center of the United States department of defense or the United States department of veterans affairs;

(C) a qualified nongovernmental research entity identified in the guidelines issued by the national institutes for health for center support groups; or

(D) the United States departments of veterans affairs, defense, or energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States secretary of health and human services to:

(I) be comparable to the system of peer review of studies and investigations used by the national institutes of health; and

(II) provide unbiased scientific review by individuals who have no interest in the outcome of the review.

(b) "Qualified individual" means an individual with health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer because:

(i) the referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or

(ii) the individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

(c) (i) "Routine patient costs" include all items and services covered by a plan of individual or group health insurance coverage when the items or services are typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(ii) The term does not include:

(A) an investigational item, device, or service that is part of the trial;

(B) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient;

(C) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(D) an item or service customarily provided and paid for by the sponsor of a clinical trial.

Section 2. Section 2-18-704, MCA, is amended to read:

"2-18-704. Mandatory provisions. (1) An insurance contract or plan issued under this part must contain provisions that permit:

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and

subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for treatment of inborn errors of metabolism, as provided for in 33-22-131.

(8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.

(b) Coverage for well-child care under subsection (8)(a) must include:

(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(ii) routine immunizations according to the schedule for immunization recommended by the immunization practice advisory committee of the U.S. department of health and human services.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit as provided for in this subsection (8).

(d) For purposes of this subsection (8):

(i) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or a health care professional supervised by a physician.

(9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance contract or plan, may be required to be paid by the insured and not by the employer.

(10) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.

(11) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

(12) (a) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(b) Coverage must include a $250 benefit for a person each year for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes.

(c) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

(e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana university system as benefits to employees, retirees, and their dependents.

(13) (a) The state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as are available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(b) The state employee group benefit plans and the Montana university system group benefits plans subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or dependent only if:

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if the plans have not received timely premium payments;

(ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(iii) the state employee group benefit plans and the Montana university system group benefits plans are ceasing to offer coverage in accordance with applicable state law. (See compiler's comments for contingent termination of certain text.)

(14) The state employee group benefit plans and the Montana university system group benefits plans must comply with the provisions of [section 1]. "

Section 3. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, [section1], 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) Sections 33-22-137, 33-22-150 through 33-22-152, and 33-22-301 apply to group or blanket policies."

Section 4. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is

exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, [section 1], 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 5. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) 33-3-308;

(e) Title 33, chapter 18, except 33-18-242;

(f) Title 33, chapter 19;

(g) 33-22-107, 33-22-131, 33-22-134, 33-22-135, [section 1], 33-22-141, 33-22-142, and 33-22-152; and

(h) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 6. Section 53-4-1005, MCA, is amended to read:

"53-4-1005. (Temporary) Benefits provided. (1) Benefits provided to participants in the program may include but are not limited to:

(a) inpatient and outpatient hospital services;

(b) physician and advanced practice registered nurse services;

(c) laboratory and x-ray services;

(d) well-child and well-baby services;

(e) immunizations;

(f) clinic services;

(g) dental services;

(h) prescription drugs;

(i) mental health and substance abuse treatment services;

(j) hearing and vision exams; and

(k) eyeglasses.

(2) The program must comply with the provisions of [section 1].

~~(2)~~(3) The department shall adopt rules, pursuant to its authority under 53-4-1009, allowing it to cover significant dental needs beyond those covered in the basic plan. Expenditures under this subsection may not exceed $100,000 in state funds, plus any matched federal funds, each fiscal year.

~~(3)~~(4) The department is specifically prohibited from providing payment for birth control contraceptives under this program.

~~(4)~~(5) The department shall notify enrollees of any restrictions on access to health care providers, of any restrictions on the availability of services by out-of-state providers, and of the methodology for an out-of-state provider to be an eligible provider. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 3, Ch. 169, L. 2007.)"

Section 7. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall administer the Montana medicaid program.

(2) The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:

(a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;

(b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

(c) giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

(3) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department; ~~and~~

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2); and

(m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as provided in [section 1].

(4) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) services of psychologists licensed under Title 37, chapter 17;

(p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

(q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(5) Services for persons qualifying for medicaid under the medically needy category of assistance, as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy category of assistance.

(6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in ~~subsections (3)(a) through (3)(l)~~ subsection (3) but may include those optional services listed in subsections (4)(a) through (4)(q) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(8) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(9) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(10) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(12) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical

services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2)."

Section 8. Codification instruction. [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, apply to [section 1].

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

Section 10. Contingent termination. [Section 6] terminates on occurrence of the contingency contained in section 15, Chapter 571, Laws of 1999.

- END -

I hereby certify that the within bill,

SB 0055, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day

of _____, 2013.

Speaker of the House

Signed this _____ day

of _____, 2013.

SENATE BILL NO. 55

INTRODUCED BY KAUFMANN, WITTICH, BANGERTER, WILLIAMS

BY REQUEST OF THE CHILDREN, FAMILIES, HEALTH, AND HUMAN SERVICES INTERIM COMMITTEE

AN ACT CLARIFYING THAT ISSUERS OF HEALTH INSURANCE COVERAGE MAY NOT DENY ROUTINE PATIENT COSTS FOR INDIVIDUALS IN AN APPROVED CLINICAL TRIAL; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-704, 33-22-101, 33-31-111, 33-35-306, 53-4-1005, AND 53-6-101, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A TERMINATION DATE.