

A-Engrossed House Bill 4040

Ordered by the House February 16
Including House Amendments dated February 16

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care for Representative Rob Nosse)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act changes the rules for how certain health care is given in this state. The Act alters how certain health care providers are licensed or regulated. The Act changes some insurance rules. The Act changes some pharmacy and drug rules. The Act takes effect when signed. (Flesch Readability Score: 79.7).

Modifies the requirements for screening a hospital patient for presumptive eligibility for financial assistance.

[Prohibits the Oregon Health Authority from requiring certain home health agencies to comply with Medicare conditions of participation.]

[Modifies the requirements for how the Department of Human Services must publish Residential Care Quality Measurement Program data.]

Removes the requirement that an applicant for a residential care facility administrator license hold a bachelor's degree in a health or social service related field.

Allows a person residing in a correctional facility to receive prerelease medical assistance benefits under certain circumstances.

[Prohibits the authority or a coordinated care organization from requiring prior authorization for medical assistance coverage for repairing complex rehabilitation technology if the repair costs \$1,500 or less.]

Modifies the requirements for meetings held by the Health Evidence Review Commission.

Modifies the composition of the Medicaid Advisory Committee.

Modifies the eligibility requirements for parent providers who are paid to provide attendant care services to their children.

[Prohibits a coordinated care organization or dental subcontractor from preventing an oral health care provider from informing consumers about their choice of providers.]

Allows a full-time dentistry student enrolled in an out-of-state dental education program to practice dentistry without a license if the student is supervised by a faculty member of a dental education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Requires casualty or health insurance policies to provide coverage for medically necessary anesthesia services, regardless of duration, for any covered procedures.

Requires dental insurers to follow certain rules for payment and denial of claims.

Requires the Legislative Policy and Research Director to develop and propose to the *[Legislative Policy and Research Committee]* **committees with jurisdiction over health care** an insurance coverage mandate impact statement policy. Directs the *[committee]* **committees** to perform due diligence in considering the proposal and authorizes the *[committee]* **committees** to modify the proposal if the *[committee]* **committees** so *[determines]* **determine**, and then to adopt the policy.

Repeals requirement that enrollees in individual or group policies or certificates of health insurance *[or members of coordinated care organizations]* be assigned by **their** insurer *[or organization]* to primary care providers under certain circumstances.

Specifies exemptions from the requirement that pharmacy services administrative organizations must register with the Department of Consumer and Business Services as third party administrators.

[Provides that the Governor shall select the chairperson of the Prescription Drug Affordability Board.]

Modifies requirements for the Prescription Drug Affordability Board's annual affordability determination for insulin products.

Allows licensees of the Occupational Therapy Licensing Board and the Oregon Board of Physical Therapy to provide psilocybin services as licensed psilocybin service facilitators while providing occupational therapy or physical therapy services.

[Authorizes a naturopathic physician to prescribe durable medical equipment and admit a patient to a hospital.] Lowers the age at which a naturopathic physician may request a retired license status from 70 years of age to *[60]* **65** years of age.

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 Includes nurse practitioners and physician associates in the definition of “attending physician”
2 for purposes of the treatment of workers’ compensable injuries.

3 Declares an emergency, effective on passage.

4 **A BILL FOR AN ACT**

5 Relating to health care; creating new provisions; amending ORS 411.447, 414.211, 414.690, 427.191,
6 442.615, 475A.325, 475A.338, 475A.372, 646A.694, 656.005, 656.214, 656.245, 656.250, 656.252,
7 656.262, 656.268, 656.325, 656.340, 656.726, 656.797, 657.170, 659A.043, 659A.046, 659A.049,
8 659A.063, 678.733, 679.025, 685.100, 685.102, 743A.145, 743B.456, 744.702, 750.055 and 750.333 and
9 section 5, chapter 575, Oregon Laws 2015; repealing ORS 743B.221; and declaring an emergency.

10 **Be It Enacted by the People of the State of Oregon:**

11 **HOSPITALS**

12 **SECTION 1.** ORS 442.615 is amended to read:

13 442.615. (1) As used in this section:

14 (a) “Financial assistance” includes:

15 (A) Charity care, as defined in ORS 442.601; or

16 (B) An adjustment to a patient’s costs for care under ORS 442.614 (1)(a).

17 (b) “Hospital” has the meaning given that term in ORS 442.612.

18 (2) Using the process prescribed by the Oregon Health Authority under subsection (3) of this
19 section, a hospital licensed under ORS 441.025 shall screen a patient for presumptive eligibility for
20 financial assistance if the patient:

21 (a) Is uninsured;

22 (b) Is enrolled in the state medical assistance program; or

23 (c) Owes the hospital more than [\$500] **\$1,500 for a single hospital encounter.**

24 (3) The authority shall adopt by rule the process for screening a patient for presumptive eligi-
25 bility for financial assistance under subsection (2) of this section. The rules and process must:

26 (a) Prohibit a hospital from requiring a patient to provide documentation or other verification;

27 (b) Ensure that the process will not cause any negative impact on the patient’s credit score;

28 (c) Require a hospital, before sending a bill to the patient, to conduct the screening and apply
29 any financial assistance for which the patient qualifies to the bill; and

30 (d) Require the hospital to notify a patient if the patient has been screened and to explain to
31 the patient, in language approved by the authority, how to apply for financial assistance if financial
32 assistance was denied, or how to apply for additional financial assistance above what the patient
33 received.

34 (4) A patient may apply for financial assistance:

35 (a) If the patient was screened for presumptive eligibility for financial assistance and was found
36 not to be eligible or the patient disagrees with the amount of the financial assistance that was of-
37 fered;

38 (b) If a patient was not screened for presumptive eligibility for financial assistance; or

39 (c) Any time up to 12 months after a patient pays for the services that the hospital provided.

40 (5) A hospital may require a patient who applies for financial assistance under subsection (4)
41 of this section to provide documentation or verification of information reported as necessary for the
42 hospital to determine the patient’s eligibility for financial assistance.

43 (6) If a patient applies for financial assistance after having paid for the services and the patient
44

1 is found to have been eligible for financial assistance when the services were provided:

2 (a) The hospital shall refund the amount of financial assistance for which the patient qualified;

3 (b) If the hospital previously determined, incorrectly, that the patient did not qualify for finan-
4 cial assistance for the services based on information provided by the patient at the time of the in-
5 correct determination, the hospital shall also pay the patient interest on the amount of financial
6 assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such
7 as legal expenses and fees, incurred by the patient in securing financial assistance; and

8 (c) If the hospital sold the debt to a collection agency or authorized a collection agency to col-
9 lect debts on behalf of the hospital, the hospital shall notify the collection agency that the debt is
10 invalid.

11 (7) If a patient applies for financial assistance and the hospital determines that the patient is
12 eligible for financial assistance based on documentation provided by the patient, the patient's eligi-
13 bility for financial assistance continues for nine months following the hospital's determination, and
14 the patient may not be required to reapply for financial assistance for services provided during that
15 nine-month period.

16 (8)(a) A hospital must have a written process that is in plain English, and in other languages
17 as required by law, for a patient to appeal a hospital's denial of financial assistance, in whole or in
18 part, and that allows the patient, or an individual acting on behalf of the patient, to correct any
19 deficiencies in documentation or to request a review of the denial by the hospital's chief financial
20 officer or the chief financial officer's designee. The authority shall prescribe by rule the require-
21 ments for the appeal process.

22 (b) If a hospital denies a patient's application for financial assistance, whether in whole or in
23 part, the hospital must notify the patient of the denial and include in the notice an explanation of
24 the hospital's appeal process.

25 (9) During the pendency of an appeal that is filed using a hospital's appeal process under sub-
26 section (8) of this section, if:

27 (a) The hospital has initiated collection activities, the hospital must suspend all collection ac-
28 tivities; and

29 (b) The hospital sold the debt under appeal to a collection agency or has authorized a collection
30 agency to collect debts on behalf of the hospital, the hospital must notify the collection agency to
31 suspend collection activities.

32
33 **RESIDENTIAL CARE**

34
35 **SECTION 2.** ORS 678.733 is amended to read:

36 678.733. (1) The Health Licensing Office may issue a residential care facility administrator li-
37 cense to an applicant who:

38 (a) Is at least 21 years of age;

39 (b) Has earned at least a high school diploma or its equivalent, as indicated by evidence of the
40 following, in a form deemed sufficient by the office:

41 (A) Completion of high school or an equivalent educational level;

42 (B) Passage of an approved high school equivalency test, including but not limited to the Gen-
43 eral Educational Development (GED) test; or

44 (C) Graduation from a post-secondary institution;

45 (c)(A) For at least two of the last five years has been employed in a professional or managerial

1 capacity in a health or social service related field, or has a combination of experience and education
2 deemed sufficient by the office; or

3 (B) Has earned at least a bachelor's degree [*in a health or social service related field*];

4 (d) Has completed at least 40 hours of training approved by the office by rule;

5 (e) Pays a licensure fee; and

6 (f) Passes an examination described in ORS 678.743.

7 (2) Evidence of the education described in subsection (1)(b) of this section may be provided by
8 a diploma or other document, or by facts, circumstances or other indicators deemed sufficient by the
9 office.

10 (3) When issuing a license under this section, the office shall consider the qualifications for
11 employment under ORS 443.004.

12 **SECTION 3. The amendments to ORS 678.733 by section 2 of this 2026 Act apply to ap-**
13 **plications for licensure under ORS 678.733 submitted to the Health Licensing Office on or**
14 **after the operative date specified in section 4 of this 2026 Act.**

15 **SECTION 4. (1) The amendments to ORS 678.733 by section 2 of this 2026 Act become**
16 **operative on January 1, 2027.**

17 **(2) The Health Licensing Office make take any action before the operative date specified**
18 **in subsection (1) of this section that is necessary to enable the office to exercise, on and**
19 **after the operative date specified in subsection (1) of this section, all of the duties, functions**
20 **and powers conferred on the office by the amendments to ORS 678.733 by section 2 of this**
21 **2026 Act.**

22 MEDICAL ASSISTANCE

23 **SECTION 5.** ORS 411.447 is amended to read:

24 411.447. (1) As used in this section, "correctional facility" means:

25 (a) A local correctional facility as defined in ORS 169.005;

26 (b) A Department of Corrections institution as defined in ORS 421.005; or

27 (c) A youth correction facility as defined in ORS 162.135.

28 (2) The Department of Human Services or the Oregon Health Authority shall:

29 (a) Suspend, instead of terminate, the medical assistance of a person who is residing in a
30 correctional facility; **or**

31 (b) **Enroll the person in the appropriate benefits package based on the person's eligibility**
32 **for prerelease benefits, as authorized by federal law.**

33 (3) Upon notification that a person described in subsection (2) of this section is not residing in
34 a correctional facility or that the person is admitted to a medical institution outside of the
35 correctional facility for a period of hospitalization, the department or the authority shall reinstate
36 the [*person's medical assistance if the person is eligible for medical assistance*] **medical assistance**
37 **benefits for which the person is eligible at the time of release or hospitalization.**

38 (4)(a) A designee of a correctional facility may apply for medical assistance on behalf of a per-
39 son, while the person is residing in the correctional facility, for the purpose of establishing eligi-
40 bility for medical assistance **prior to release, with full benefits** upon the person's release from the
41 correctional facility or during a period of hospitalization that will occur outside of the correctional
42 facility.

43 (b) The designee may obtain information necessary to determine eligibility for medical assist-
44

1 ance, including the person's Social Security number or information that is not otherwise subject to
2 disclosure under ORS 411.320 or 413.175. The information obtained under this paragraph may be
3 used only for the purpose of assisting the person in applying for medical assistance and may not be
4 redisclosed without the person's authorization.

5 *[(c) If the person is determined eligible for medical assistance, the effective date of the person's*
6 *medical assistance shall be the date the person is released from the correctional facility or the date the*
7 *person begins the period of hospitalization outside of the correctional facility.]*

8 (5) This section does not extend eligibility to an otherwise ineligible person or extend medical
9 assistance to a person if matching federal funds are not available to pay for the medical assistance.

10 **SECTION 6.** ORS 414.690 is amended to read:

11 414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and in-
12 formation from stakeholders representing consumers, advocates, providers, carriers and employers
13 in conducting the work of the commission.

14 **(2)(a) No less than 14 days before a meeting, the Oregon Health Authority shall post to**
15 **the authority's website and to the website of the commission:**

16 **(A) The agenda for the meeting; and**

17 **(B) A list of all recommendations before the commission for review, including, but not**
18 **limited to:**

19 **(i) A drug or drug class review;**

20 **(ii) A technology review; and**

21 **(iii) Coverage guidance.**

22 **(b) Except as provided by the authority by rule, once the authority has posted an agenda**
23 **under this subsection, the agenda may not be changed.**

24 *[(2)]* **(3)(a) The commission shall actively solicit public involvement through a public meeting**
25 **process to guide health resource allocation decisions [that includes, but is not limited to:], in which**
26 **the public is invited to testify in writing and in person. Except when more than 50 written**
27 **comments from the public are received, the authority shall post to the commission's website**
28 **and provide each commission member with the written comments received from the public**
29 **no later than 48 hours after the close of the public comment period.**

30 **(b) The public meeting process described in this subsection shall include, but not be lim-**
31 **ited to:**

32 *[(a)]* **(A) Providing members of the public the opportunity to provide input on the selection of**
33 **any vendor that provides research and analysis to the commission; and**

34 *[(b)]* **(B) Inviting public comment on any research or analysis tool or health economic measures**
35 **to be relied upon by the commission in the commission's decision-making.**

36 *[(3)(a)]* **(4)(a) The commission shall develop and maintain a list of health services ranked by**
37 **priority, from the most important to the least important, representing the comparative benefits of**
38 **each service to the population to be served.**

39 **(b) Except as provided in ORS 414.701, the commission may not rely upon any quality of life in**
40 **general measures, either directly or by considering research or analysis that relies on a quality of**
41 **life in general measure, in determining:**

42 **(A) Whether a service is cost-effective;**

43 **(B) Whether a service is recommended; or**

44 **(C) The value of a service.**

45 **(c) The list must be submitted by the commission pursuant to subsection [(5)] (6) of this section**

1 and is not subject to alteration by any other state agency.

2 [(4)] (5) In order to encourage effective and efficient medical evaluation and treatment, the
3 commission:

4 (a) May include clinical practice guidelines in its prioritized list of services. The commission
5 shall actively solicit testimony and information from the medical community and the public to build
6 a consensus on clinical practice guidelines developed by the commission.

7 (b) May include statements of intent in its prioritized list of services. Statements of intent should
8 give direction on coverage decisions where medical codes and clinical practice guidelines cannot
9 convey the intent of the commission.

10 (c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, in-
11 cluding drug therapies, in determining their relative importance using peer-reviewed medical litera-
12 ture.

13 [(5)] (6) The commission shall report the prioritized list of services to the Oregon Health Au-
14 thority for budget determinations by July 1 of each even-numbered year.

15 [(6)] (7) The commission shall make its report during each regular session of the Legislative
16 Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Rep-
17 resentatives and the President of the Senate and post to the Oregon Health Authority's website,
18 along with a solicitation of public comment, an assessment of the impact on access to medically
19 necessary treatment and services by persons with disabilities or chronic illnesses resulting from the
20 commission's prior use of any quality of life in general measures or any research or analysis that
21 referred to or relied upon a quality of life in general measure.

22 [(7)] (8) The commission may alter the list during the interim only as follows:

23 (a) To make technical changes to correct errors and omissions;

24 (b) To accommodate changes due to advancements in medical technology or new data regarding
25 health outcomes;

26 (c) To accommodate changes to clinical practice guidelines; and

27 (d) To add statements of intent that clarify the prioritized list.

28 [(8)] (9) If a service is deleted or added during an interim and no new funding is required, the
29 commission shall report to the Speaker of the House of Representatives and the President of the
30 Senate. However, if a service to be added requires increased funding to avoid discontinuing another
31 service, the commission shall report to the Emergency Board to request the funding.

32 [(9)] (10) The prioritized list of services remains in effect for a two-year period beginning no
33 earlier than October 1 of each odd-numbered year.

34 [(10)(a)] (11)(a) As used in this section, "peer-reviewed medical literature" means scientific
35 studies printed in journals or other publications that publish original manuscripts only after the
36 manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy,
37 validity and reliability.

38 (b) "Peer-reviewed medical literature" does not include internal publications of pharmaceutical
39 manufacturers.

40 **SECTION 7.** ORS 414.211 is amended to read:

41 414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than 15
42 members appointed by the Governor.

43 (2) The committee shall be composed of:

44 (a) A physician licensed under ORS chapter 677;

45 (b) Two members of health care consumer groups that include Medicaid recipients;

1 (c) [Two] **Four** Medicaid recipients, [one of whom shall be a] **including one** person with a dis-
2 ability **and one person who qualifies for medical assistance based on modified adjusted gross**
3 **income criteria;**

4 (d) The Director of the Oregon Health Authority or [designee] **a manager of the division of**
5 **the authority that administers the state medical assistance program;**

6 (e) The Director of Human Services or designee;

7 (f) Health care providers;

8 (g) Persons associated with health care organizations, including but not limited to coordinated
9 care organizations under contract to the Medicaid program; and

10 (h) Members of the general public.

11 (3) In making appointments, the Governor shall consult with appropriate professional and other
12 interested organizations. All members appointed to the committee shall be familiar with the medical
13 needs of low income persons.

14 (4) The term of office for each member shall be [two] **three** years, but each member shall serve
15 at the pleasure of the Governor.

16 (5) Members of the committee shall receive no compensation for their services but, subject to
17 any applicable state law, shall be allowed actual and necessary travel expenses incurred in the
18 performance of their duties from the Oregon Health Authority Fund.

19 **SECTION 8. The amendments to ORS 414.211 by section 7 of this 2026 Act become oper-**
20 **ative on July 10, 2027.**

21 **SECTION 9. Notwithstanding ORS 414.211, the Medicaid Advisory Committee shall be**
22 **composed of:**

23 (1) **For the period between the effective date of this 2026 Act and July 9, 2026, at least**
24 **10 percent Medicaid recipients; and**

25 (2) **For the period between July 10, 2026, and July 9, 2027, at least 20 percent Medicaid**
26 **recipients.**

27 **SECTION 10. Section 9 of this 2026 Act is repealed on January 2, 2028.**

28
29 **PARENT PROVIDERS**

30
31 **SECTION 11. ORS 427.191 is amended to read:**

32 427.191. (1) As used in this section:

33 (a) "Agency" means an agency that hires, trains and supervises direct support professionals us-
34 ing state funds received from the Department of Human Services.

35 (b) "Attendant care services" means services provided directly to an individual with a disability
36 to assist with activities of daily living, instrumental activities of daily living and health-related
37 tasks.

38 (c) "Child" means an individual under 18 years of age who:

39 (A) Has a developmental or intellectual disability; or

40 (B) Meets the eligibility criteria to receive services under the Medically Fragile (Hospital)
41 Model Waiver or the Medically Involved Children's Waiver approved by the Centers for Medicare
42 and Medicaid Services under 42 U.S.C. 1396n(c).

43 (d) "Client" means an individual who receives attendant care services.

44 (e) "Client child" means a child who receives attendant care services from the child's parent.

45 (f) "Developmental disability services" has the meaning given that term in ORS 427.101.

1 (g) "Direct support professional" means an individual who is hired, employed, trained, paid and
2 supervised by an agency to provide attendant care services to a client of the agency.

3 (h) "Nonparent caregiver" means a direct support professional, personal support worker or
4 similar provider who is paid to provide attendant care services to clients who are not the provider's
5 children.

6 (i) "Parent" includes a:

7 (A) Natural or adoptive parent of a child;

8 (B) Stepparent of a child; and

9 (C) Legal guardian of a child.

10 (j)(A) "Parent provider" means a parent who is paid to provide attendant care services to the
11 parent's minor child.

12 (B) "Parent provider" does not include a parent who is paid to provide attendant care services
13 to a child who is 18 years of age or older.

14 (k)(A) "Personal support worker" means an individual who is employed by a client or the client's
15 representative and paid to provide attendant care services to the client.

16 (B) "Personal support worker" does not include a direct support professional.

17 (L) "State plan" means Oregon's state plan for medical assistance, described in 42 U.S.C. 1396a,
18 approved by the Centers for Medicare and Medicaid Services.

19 (m) "Very high behavioral needs" means a minor child's extraordinary needs for support due to
20 the child's behavioral condition as indicated by a federally approved functional needs assessment
21 adopted by the department that assigns the child to the highest service level.

22 (n) "Very high medical needs" means a minor child's extraordinary needs for support due to the
23 child's medical condition as indicated by a federally approved functional needs assessment adopted
24 by the department that assigns the child to the highest service level.

25 (2) Subject to rules adopted under subsection (8) of this section, to ORS 427.194 and to available
26 funding, the department shall administer a program to compensate parents to provide attendant care
27 services to the parents' children who have been assessed by the department to have very high
28 medical or very high behavioral needs.

29 (3) To be eligible for the program described in this section:

30 (a) A parent provider must be employed *[by an agency and not by the child or the other parent*
31 *of the child]* **as a direct support professional or a personal support worker;**

32 (b) The parent provider may not be paid to provide attendant care services to the client child
33 by an agency that is owned by the parent, the **client** child or any family member or for which the
34 parent or other family member serves in any administrative or leadership capacity, including as a
35 member of a board of directors; and

36 (c) The agency employing the parent provider to provide attendant care services to the client
37 child:

38 (A) May not employ a parent provider as an independent contractor;

39 (B) Shall pay parent providers overtime at the same rate and under the same circumstances as
40 direct support professionals who are not parent providers;

41 (C) Except as authorized by the department by rule, may not pay providers of attendant care
42 services, including parent providers, to provide services to a [*minor*] child during school hours un-
43 less the [*minor*] child is temporarily at home recovering from surgery or illness and the temporary
44 absence from school is recommended by the child's health care provider; and

45 (D) May not pay providers of attendant care services, including parent providers, to provide

1 services to a [*minor*] child during school hours due to the determination of a school district or due
2 to the choice of a parent of the [*client*] child to:

3 (i) Have the child regularly attend school less than the number of school hours attended by
4 students without disabilities who are in the same grade and the same school district as the [*client*]
5 child;

6 (ii) Homeschool the [*client*] child; or

7 (iii) Enroll the [*client*] child in a private school that offers fewer school hours than the school
8 hours offered by the local public school to the majority of students in the same grade as the
9 [*client*] child.

10 (4) Subsection (3)(c)(D) of this section does not prohibit a school district or other entity from
11 compensating parents of students with disabilities for providing support for educational activities
12 that would otherwise be the responsibility of the school district.

13 (5) A parent provider, during the hours that the parent provider is paid to provide one-on-one
14 attendant care services to the client child:

15 (a) May not be responsible for a vulnerable adult who requires physical care and monitoring;

16 (b) May not be responsible for the care of [*a child*] **an individual**, other than the client child,
17 who is under 10 years of age and shall have another caregiver immediately available at all times
18 to attend to the needs of the [*child*] **individual**; and

19 (c) Unless they are included as a goal or service in the **client** child's individual support plan
20 and related to the **client** child's disability-related support needs, may not perform tasks that are not
21 for the primary benefit of the client child, including but not limited to:

22 (A) Grocery shopping for the household;

23 (B) Housekeeping not required for the disability-related support needs of the client child;

24 (C) Remote work or operation of a home business; or

25 (D) Transporting individuals other than the client child to or from activities or appointments.

26 (6) If required by the Centers for Medicare and Medicaid Services, the department may require
27 a parent provider to assign an alternative legal representative for the client child to make decisions
28 about or manage the development and implementation of the client child's individual support plan.

29 The assignment:

30 (a) Must be on a form prescribed by the department; and

31 (b) Must clearly state that the assignment is limited to decisions regarding the development and
32 implementation of the **client** child's individual support plan and does not limit the authority of the
33 parent provider to make decisions for the client child with respect to health care, education or re-
34 ligious training.

35 (7) A parent provider is subject to the requirements of mandatory reporting of abuse under ORS
36 124.060 and 419B.010, 24 hours per day, seven days per week.

37 (8) The department shall adopt rules for the program described in this section using an advisory
38 committee appointed under ORS 183.333 that represents the interests of parents, children with de-
39 velopmental or intellectual disabilities, adults with disabilities, agencies, organizations of direct
40 support professionals and personal support workers and organizations that advocate for persons with
41 disabilities. The rules must include all of the following:

42 (a) Strategies to safeguard nonparent caregivers and avoid the displacement of nonparent
43 caregivers by parent providers;

44 (b) Requirements for agencies to demonstrate consistent efforts to recruit, train and retain
45 nonparent caregivers;

1 (c) **Requirements for appropriate training, background checks and oversight, including**
2 training requirements for:

3 (A) Parent providers regarding federal and state administrative rules regulating home-based and
4 community-based services, including the impact of the rules on parent-child relationships with re-
5 spect to discipline, supervision, physical intervention and self-determination of client children during
6 the hours that the parent provider is being paid to provide attendant care services;

7 (B) Client children to learn to advocate for themselves with respect to choosing and managing
8 direct support professionals before and after reaching 18 years of age; and

9 (C) Community developmental disability programs related to the employment of parent providers,
10 including on how to support families to manage issues concerning conflicts of interest, provider
11 recruitment and retention and the empowerment of the client child to have a meaningful voice in
12 the selection of the client child's *[direct support professionals]* **caregivers;**

13 (d) A process for a client child to object to the hiring of any caregiver, including the child's
14 parent, or to raise concerns about a provider's caregiving;

15 (e) Procedures to ensure that the program described in this section is implemented consistently
16 and equitably throughout this state;

17 (f) A requirement that any appeal related to the requirements of or benefits under the program
18 is the sole responsibility of the central office staff of the department;

19 **(g) Procedures to ensure program integrity and prevent duplicate payment for the same**
20 **service hours; and**

21 *[(g)]* **(h)** Other requirements that the department deems necessary to carry out the provisions
22 of this section.

23 (9) The department may adopt rules necessary to manage the cost, size and growth rate of the
24 program described in this section that are necessary to protect the eligibility for and levels of ser-
25 vices under programs serving individuals receiving developmental disability services provided for in
26 the state plan, including the development of criteria to limit the number of children eligible to par-
27 ticipate in the program.

28 (10) Annually, the department shall report to the interim committees of the Legislative Assembly
29 related to human services or, if the Legislative Assembly is in session, to the committees of the
30 Legislative Assembly related to human services, in the manner provided in ORS 192.245, updates on
31 the program described in this section, including:

32 (a) The number of client children receiving attendant care services, the number of children re-
33 ceiving the services from parent providers and the number of children receiving the services from
34 nonparent caregivers;

35 (b) The number of hours of attendant care services provided by parent providers and number
36 of hours of attendant care services provided by nonparent caregivers;

37 (c) A comparison of the cost per child of providing attendant care services by parent providers
38 under the program with the cost per child of providing attendant care services by nonparent
39 caregivers; and

40 (d) A report on the adequacy of the direct care workforce in this state to provide services to
41 all children with developmental disability services who are eligible for attendant care services.

42
43 **DENTAL**

44
45 **SECTION 12.** ORS 679.025 is amended to read:

1 679.025. (1) A person may not practice dentistry or purport to be a dentist without a valid li-
2 cense to practice dentistry issued by the Oregon Board of Dentistry.

3 (2) Subsection (1) of this section does not apply to:

4 (a) Dentists licensed in another state or country making a clinical presentation sponsored by a
5 bona fide dental society or association or an accredited dental educational institution approved by
6 the board.

7 (b) Bona fide full-time students of dentistry who, during the period of their enrollment and as a
8 part of the course of study in an Oregon accredited dental education program, engage in clinical
9 studies on the premises of such institution or in a clinical setting located off the premises of the
10 institution if the facility, the instructional staff and the course of study to be pursued at the off-
11 premises location meet minimum requirements prescribed by the rules of the board and the clinical
12 study is performed under the indirect supervision of a member of the faculty.

13 (c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a
14 part of the course of study in a dental education program located outside of Oregon that is accred-
15 ited by the Commission on Dental Accreditation of the American Dental Association or its successor
16 [agency] **organization**, engage in community-based or clinical studies as an elective or required ro-
17 tation in a clinical setting located in Oregon if the community-based or clinical studies meet mini-
18 mum requirements prescribed by the rules of the board and are performed under the indirect
19 supervision of a [*member of the faculty of the Oregon Health and Science University School of*
20 *Dentistry*] **faculty member of a dental education program accredited by the Commission on**
21 **Dental Accreditation of the American Dental Association, or its successor organization.**

22 (d) Candidates who are preparing for a licensure examination to practice dentistry and whose
23 application has been accepted by the board or its agent, if the clinical preparation is conducted in
24 a clinic located on premises approved for that purpose by the board and if the procedures are lim-
25 ited to examination only. This exception shall exist for a period not to exceed two weeks imme-
26 diately prior to a regularly scheduled licensure examination.

27 (e) Dentists practicing in the discharge of official duties as employees of the United States
28 Government and any of its agencies.

29 (f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching ac-
30 tivities and while employed in accredited dental educational institutions.

31 (g) Dentists who are employed by public health agencies and who are not engaged in the direct
32 delivery of clinical dental services to patients.

33 (h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of their
34 duties.

35 (i) Persons qualified to perform services relating to general anesthesia or sedation under the
36 direct supervision of a licensed dentist.

37 (j)(A) Dentists licensed in another country and in good standing, while practicing dentistry
38 without compensation for no more than five consecutive days in any 12-month period, provided the
39 dentist submits an application to the board at least 10 days before practicing dentistry under this
40 subparagraph and the application is approved by the board.

41 (B) Dentists licensed in another state or United States territory and practicing in this state
42 under ORS 676.347.

43 (k) Persons practicing dentistry upon themselves as the patient.

44 (L) Dental hygienists, dental assistants or dental technicians performing services under the
45 supervision of a licensed dentist in accordance with the rules adopted by the board.

1 (m) A person licensed as a denturist under ORS 680.500 to 680.565 engaged in the practice of
2 denture technology.

3 (n) An expanded practice dental hygienist who renders services authorized by a permit issued
4 by the board pursuant to ORS 680.200.

5 **SECTION 13.** (1) The amendments to ORS 679.025 by section 12 of this 2026 Act become
6 operative on January 1, 2027.

7 (2) The Oregon Board of Dentistry make take any action before the operative date spec-
8 ified in subsection (1) of this section that is necessary to enable the board to exercise, on
9 and after the operative date specified in subsection (1) of this section, all of the duties,
10 functions and powers conferred on the board by the amendments to ORS 679.025 by section
11 12 of this 2026 Act.

12
13 **COMMERCIAL HEALTH INSURANCE**
14

15 **SECTION 14.** Section 15 of this 2026 Act is added to and made a part of the Insurance
16 Code.

17 **SECTION 15.** (1) A group or individual policy of casualty insurance or health insurance,
18 including a health benefit plan as defined in ORS 743B.005, shall provide coverage for med-
19 ically necessary anesthesia services, regardless of the duration, for any procedure covered
20 by the policy.

21 (2) A policy described in subsection (1) of this section may not deny payment or re-
22 imbursement for anesthesia services solely because the duration of care exceeded a preset
23 time limit.

24 **SECTION 16.** Section 15 of this 2026 Act applies to group or individual policies of casualty
25 insurance or health insurance, including health benefit plans, that are issued, renewed or
26 extended on or after January 1, 2027.

27 **SECTION 17.** Sections 18, 20 and 21 of this 2026 Act are added to and made a part of the
28 Insurance Code.

29 **SECTION 18.** As used in ORS 743B.456 and sections 20 and 21 of this 2026 Act:

30 (1) “Dental insurance plan” means a policy or certificate of insurance or other contract
31 that provides only a dental benefit.

32 (2) “Dental insurer” means an insurer that offers a policy or certificate of insurance or
33 other contract that provides only a dental benefit.

34 (3) “Dental provider” means a person licensed, certified or otherwise permitted by laws
35 of this state to administer dental services in the ordinary course of business or practice of
36 a profession.

37 **SECTION 19.** ORS 743B.456 is amended to read:

38 743B.456. (1) As used in this section, [*“dental insurer” means an insurer that offers a policy or*
39 *certificate of insurance or other contract, that provides only a dental benefit*] “clean claim” means a
40 claim that has no defect or error, is understandable and reasonably legible, includes required
41 substantiating documentation and does not require special treatment that delays timely
42 payment on the claim.

43 (2) A dental insurer may pay a claim for reimbursement made by a dental care provider using
44 a credit card or electronic funds transfer payment method that imposes on the provider a fee or
45 similar charge to process the payment if:

1 (a) The dental insurer notifies the provider, in advance, of the potential fees or other charges
2 associated with the use of the credit card or electronic funds transfer payment method;

3 (b) The dental insurer offers the provider an alternative payment method that does not impose
4 fees or similar charges on the provider; and

5 (c) The provider or a designee of the provider elects to accept a payment of the claim using the
6 credit card or electronic funds transfer payment method.

7 (3) If a dental insurer contracts with a vendor to process payments of dental providers' claims,
8 the dental insurer shall require the vendor to comply with the provisions of subsection (2)(a) of this
9 section.

10 (4) **Except as provided in this subsection, when a claim under a dental insurance plan is**
11 **submitted to a dental insurer by a dental provider on behalf of a beneficiary, the dental**
12 **insurer shall pay a clean claim or deny the claim not later than 45 days after the date on**
13 **which the dental insurer receives the claim. If a dental insurer requires additional informa-**
14 **tion before payment of a claim, not later than 45 days after the date on which the dental**
15 **insurer receives the claim, the dental insurer shall notify the beneficiary and the dental**
16 **provider in writing or electronically, and give the beneficiary and the dental provider an ex-**
17 **planation of the additional information needed to process the claim. The dental insurer shall**
18 **pay a clean claim or deny the claim not later than 45 days after the date on which the dental**
19 **insurer receives the additional information.**

20 (5) **A contract between a dental insurer and a dental provider may not include a provision**
21 **governing payment of claims that limits the rights and remedies available to a provider un-**
22 **der this section or has the effect of relieving either party of its obligations under this sec-**
23 **tion.**

24 (6) **A dental insurer shall establish a method of communicating to dental providers the**
25 **procedures and information necessary to complete claim forms. The procedures and infor-**
26 **mation must be reasonably accessible to dental providers.**

27 (7) **This section does not create an assignment of payment to a dental provider.**

28 **SECTION 20. (1) As used in this section, "refund" means the return, either directly or**
29 **through an offset to a future claim, of some or all of a payment already received by a dental**
30 **provider.**

31 (2) **Except in the case of fraud or abuse of billing, and except as provided in subsections**
32 **(3) and (5) of this section, a dental insurer may not:**

33 (a) **Request from a dental provider a refund of a payment previously made to satisfy a**
34 **claim unless the dental insurer:**

35 (A) **Requests the refund in writing or electronically on or before the last day of the pe-**
36 **riod specified by the contract with the dental provider or 18 months after the date the pay-**
37 **ment was made, whichever is earlier; and**

38 (B) **Specifies in the written or electronic request why the dental insurer believes the**
39 **dental provider owes the refund.**

40 (b) **Request that a contested refund be paid earlier than six months after the dental**
41 **provider receives the request.**

42 (3) **A dental insurer may not do the following for reasons related to coordination of**
43 **benefits with another dental insurer or entity responsible for payment of a claim:**

44 (a) **Request from a dental provider a refund of a payment previously made to satisfy a**
45 **claim unless the dental insurer:**

1 (A) Requests the refund in writing or electronically within 45 days after the date the
2 payment was made;

3 (B) Specifies in the written or electronic request why the dental insurer believes the
4 provider owes the refund; and

5 (C) Includes in the written or electronic request the name and mailing address of the
6 other dental insurer or entity that has primary responsibility for payment of the claim.

7 (b) Request that a contested refund be paid earlier than six months after the dental
8 provider receives the request.

9 (4) If a dental provider fails to contest a refund request in writing or electronically to the
10 dental insurer within 30 days after receiving the request, the request is deemed accepted and
11 the dental provider must pay the refund within 30 days after the request is deemed accepted.
12 If the dental provider has not paid the refund within 30 days after the request is deemed
13 accepted, the dental insurer may recover the amount through an offset to a future claim.

14 (5) A dental insurer may at any time request from a dental provider a refund of a pay-
15 ment previously made to satisfy a claim if:

16 (a) A third party, including a government entity, is found responsible for satisfaction of
17 the claim as a consequence of liability imposed by law; and

18 (b) The dental insurer is unable to recover directly from the third party because the third
19 party has already paid or will pay the provider for the dental services covered by the claim.

20 (6) If a contract between a dental insurer and a dental provider conflicts with this sec-
21 tion, the provisions of this section prevail. However, nothing in this section prohibits a dental
22 provider from choosing at any time to refund to a dental insurer any payment previously
23 made to satisfy a claim.

24 (7) This section neither permits nor precludes a dental insurer from recovering from a
25 subscriber, enrollee or beneficiary any amounts paid to a dental provider for benefits to
26 which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions
27 of the dental insurance plan, insurance policy or other benefit agreement.

28 **SECTION 21.** A dental provider that bills a dental insurer for covered services provided
29 to an individual who is insured under a dental insurance plan shall be reimbursed by the
30 insurer by a direct payment issued to the dental provider.

31 **SECTION 22.** Sections 18, 20 and 21 of this 2026 Act and the amendments to ORS 743B.456
32 by section 19 of this 2026 Act become operative on January 1, 2028.

33 **SECTION 23.** (1) As used in this section and section 24 of this 2026 Act, “insurance cov-
34 erage mandate” means a proposed legislative measure that requires payment for certain
35 services of health care providers or that requires an offering of health insurance coverage
36 by an insurer or a health care service contractor as a component of an individual or group
37 health insurance policy.

38 (2) The Legislative Policy and Research Director shall develop, as a pilot program, an
39 insurance coverage mandate impact statement template. The template must solicit the in-
40 formation sought in section 24 of this 2026 Act and must take into consideration:

41 (a) Sources of data to be considered in the preparation of an insurance coverage mandate
42 impact statement for proposed legislation; and

43 (b) Sources of research to be considered in the preparation of an insurance coverage
44 mandate impact statement.

45 (3) In preparing the template, the director shall consider models used in other states and

1 in academic research for assessing the impacts of proposed insurance coverage mandate
2 legislation and other formal actions undertaken by national, state and local government en-
3 tities and other entities in the United States, including educational institutions.

4 (4) The director shall confer with the chairs and vice chairs of those committees of the
5 Legislative Assembly having jurisdiction over health care and, based on that conferral,
6 select up to three Senate measures and up to three House measures that were enacted
7 during the 2025 regular session of the Legislative Assembly on which to apply the insurance
8 coverage mandate impact statement template.

9 (5) Following selection of the measures described in subsection (4) of this section, the
10 director shall apply the template to each of the selected measures and prepare draft insur-
11 ance coverage mandate impact statements for each measure. The director shall present a
12 preliminary report to the committees with jurisdiction over health care on or before Sep-
13 tember 15, 2026, that reports on:

14 (a) The template methodology and review process;

15 (b) The director's experience in preparing draft impact statements; and

16 (c) The specific findings of the draft impact statements prepared for the test measures.

17 (6) Based on feedback provided by the committees with jurisdiction over health care, the
18 director may modify the template and prepare final insurance coverage mandate impact
19 statements on the test measures. The director shall present the final impact statements and
20 the final process report summarizing the methodology used to prepare and review impact
21 statements to the policy committees that had heard the test measures during the 2025 reg-
22 ular session of the Legislative Assembly. The director shall present the statements and final
23 report to the committees on or before December 15, 2026.

24 (7) Following the presentations described in subsection (5) of this section and following
25 or contemporaneously with the presentations described in subsection (6) of this section and
26 taking into account provided feedback, the director shall propose to the committees with
27 jurisdiction over health care a policy that describes the objectives, content and form of an
28 insurance coverage mandate impact statement and the procedures to be followed in the
29 preparation of those statements. After conducting due deliberations in which the committees
30 may make modifications to the policy, the committees shall adopt a policy on the preparation
31 of insurance coverage mandate impact statements. The policy shall include guidance on when
32 an insurance coverage mandate impact statement must be posted online on the Legislative
33 Assembly website, relative to the location in the legislative process of the associated legis-
34 lative measure.

35 **SECTION 24.** An insurance coverage mandate impact statement required to be developed
36 under section 23 of this 2026 Act shall include but need not be limited to the following:

37 (1) The evidence that exists to document the medical need for the treatment or service
38 covered under the proposed legislative measure;

39 (2) The extent of the coverage under the proposed measure;

40 (3) Whether the proposed measure ensures more or less equitable access to treatment
41 or services by residents of this state;

42 (4) Whether denying the coverage under the proposed measure would disproportionately
43 impact individuals described in ORS 746.021 and, if so, a description of the impact;

44 (5) Whether the coverage under the proposed measure is an essential health benefit as
45 defined in ORS 731.097;

1 **(6) A listing of other state or federal laws that relate to the proposed measure, including**
2 **whether other states are defraying the cost of similar coverage in accordance with 42**
3 **U.S.C. 18031(d)(3), as amended and in effect on the effective date of this 2026 Act;**

4 **(7) The extent to which the coverage in the proposed measure is already provided by the**
5 **Public Employees' Benefit Board, the Oregon Educators Benefit Board or individual, small**
6 **employer group and large employer group health insurance plans;**

7 **(8) The extent to which the coverage in the proposed measure is provided in the state**
8 **medical assistance program as prescribed by the Oregon Health Authority under ORS 414.065**
9 **or in Medicare Parts A through D; and**

10 **(9) The extent to which a lack of the coverage in the proposed measure results in finan-**
11 **cial hardship to residents of this state.**

12 **SECTION 25. No later than September 15, 2027, the Legislative Policy and Research Di-**
13 **rector shall report to the Legislative Assembly in the manner provided under ORS 192.245**
14 **on recommendations for changes to improve upon the review of proposed insurance coverage**
15 **mandates during regular or special sessions of the Legislative Assembly. The recommen-**
16 **dations may include legislative proposals or explanations of the need for additional resources.**

17 **SECTION 26. ORS 743B.221 is repealed.**

18 **SECTION 27. Section 5, chapter 575, Oregon Laws 2015, as amended by section 8, chapter 26,**
19 **Oregon Laws 2016, section 19, chapter 489, Oregon Laws 2017, and section 15, chapter 37, Oregon**
20 **Laws 2022, is amended to read:**

21 **Sec. 5.** (1) Sections 1 to 4, chapter 575, Oregon Laws 2015, are repealed on December 31, 2027.

22 (2) Section 3, chapter 489, Oregon Laws 2017, is repealed on December 31, 2027.

23 *[(3) The amendments to section 8 of this 2022 Act by section 14 of this 2022 Act become operative*
24 *on December 31, 2027.]*

25 **SECTION 28. ORS 750.055 is amended to read:**

26 750.055. (1) The following provisions apply to health care service contractors to the extent not
27 inconsistent with the express provisions of ORS 750.005 to 750.095:

28 (a) ORS 705.137, 705.138 and 705.139.

29 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
30 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
31 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
32 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

33 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
34 including ORS 732.582, and ORS 732.650 to 732.689.

35 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
36 to 733.780.

37 (e) ORS 734.014 to 734.440.

38 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
39 742.542.

40 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
41 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
42 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
43 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

44 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
45 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,

1 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
2 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
3 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
4 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

5 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
6 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
7 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
8 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
9 743B.407, 743B.420, 743B.423, 743B.430, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475,
10 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and 743B.800.

11 (j) The following provisions of ORS chapter 744:

12 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
13 ers;

14 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

15 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

16 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
17 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

18 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
19 cept in the case of group practice health maintenance organizations that are federally qualified
20 pursuant to Title XIII of the Public Health Service Act:

21 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
22 ates an in-house drug outlet.

23 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
24 practitioner associated with a group practice health maintenance organization.

25 (3) For the purposes of this section, health care service contractors are insurers.

26 (4) Any for-profit health care service contractor organized under the laws of any other state that
27 is not governed by the insurance laws of the other state is subject to all requirements of ORS
28 chapter 732.

29 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
30 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

31 (b) A health care service contractor's classification as a domestic insurance company under
32 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
33 to 734.710.

34 (6) The Director of the Department of Consumer and Business Services may, after notice and
35 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
36 and 750.045 that are necessary for the proper administration of these provisions.

37 **SECTION 29.** ORS 750.055, as amended by section 7, chapter 388, Oregon Laws 2025, is
38 amended to read:

39 750.055. (1) The following provisions apply to health care service contractors to the extent not
40 inconsistent with the express provisions of ORS 750.005 to 750.095:

41 (a) ORS 705.137, 705.138 and 705.139.

42 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
43 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
44 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
45 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

1 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
2 including ORS 732.582, and ORS 732.650 to 732.689.

3 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
4 to 733.780.

5 (e) ORS 734.014 to 734.440.

6 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
7 742.542.

8 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
9 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
10 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
11 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

12 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
13 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
14 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
15 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
16 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
17 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

18 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
19 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
20 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
21 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
22 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
23 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
24 743B.800.

25 (j) The following provisions of ORS chapter 744:

26 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
27 ers;

28 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

29 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

30 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
31 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

32 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
33 cept in the case of group practice health maintenance organizations that are federally qualified
34 pursuant to Title XIII of the Public Health Service Act:

35 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
36 ates an in-house drug outlet.

37 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
38 practitioner associated with a group practice health maintenance organization.

39 (3) For the purposes of this section, health care service contractors are insurers.

40 (4) Any for-profit health care service contractor organized under the laws of any other state that
41 is not governed by the insurance laws of the other state is subject to all requirements of ORS
42 chapter 732.

43 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
44 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

45 (b) A health care service contractor's classification as a domestic insurance company under

1 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
2 to 734.710.

3 (6) The Director of the Department of Consumer and Business Services may, after notice and
4 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
5 and 750.045 that are necessary for the proper administration of these provisions.

6 **SECTION 30.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
7 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
8 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
9 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
10 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
11 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
12 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,
13 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
14 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
15 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
16 2024, section 22, chapter 70, Oregon Laws 2024, section 163, chapter 73, Oregon Laws 2024, sections
17 6 and 8, chapter 388, Oregon Laws 2025, section 6, chapter 536, Oregon Laws 2025, and section 19,
18 chapter 539, Oregon Laws 2025, is amended to read:

19 750.055. (1) The following provisions apply to health care service contractors to the extent not
20 inconsistent with the express provisions of ORS 750.005 to 750.095:

21 (a) ORS 705.137, 705.138 and 705.139.

22 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
23 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
24 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
25 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

26 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
27 including ORS 732.582, and ORS 732.650 to 732.689.

28 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
29 to 733.780.

30 (e) ORS 734.014 to 734.440.

31 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
32 742.542.

33 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
34 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
35 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
36 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

37 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
38 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
39 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
40 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
41 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
42 743A.260, 743A.310 and 743A.315.

43 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
44 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
45 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,

1 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
2 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
3 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
4 743B.800.

5 (j) The following provisions of ORS chapter 744:

6 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
7 ers;

8 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

9 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

10 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
11 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

12 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
13 cept in the case of group practice health maintenance organizations that are federally qualified
14 pursuant to Title XIII of the Public Health Service Act:

15 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
16 ates an in-house drug outlet.

17 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
18 practitioner associated with a group practice health maintenance organization.

19 (3) For the purposes of this section, health care service contractors are insurers.

20 (4) Any for-profit health care service contractor organized under the laws of any other state that
21 is not governed by the insurance laws of the other state is subject to all requirements of ORS
22 chapter 732.

23 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
24 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

25 (b) A health care service contractor's classification as a domestic insurance company under
26 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
27 to 734.710.

28 (6) The Director of the Department of Consumer and Business Services may, after notice and
29 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
30 and 750.045 that are necessary for the proper administration of these provisions.

31 **SECTION 31.** ORS 750.333 is amended to read:

32 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
33 arrangement:

34 (a) ORS 705.137, 705.138 and 705.139.

35 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
36 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
37 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
38 731.992.

39 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

40 (d) ORS 734.014 to 734.440.

41 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

42 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
43 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and 743B.221*].

44 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
45 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,

1 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
2 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
3 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
4 743A.252, 743A.260 and 743A.310.

5 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
6 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
7 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
8 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
9 743B.423, 743B.430, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601, 743B.607
10 and 743B.610.

11 (i) The following provisions of ORS chapter 744:

12 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
13 ers;

14 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

15 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

16 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

17 (2) For the purposes of this section:

18 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

19 (b) References to certificates of authority are references to certificates of multiple employer
20 welfare arrangement.

21 (c) Contributions are premiums.

22 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
23 insurance.

24 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
25 implement the provisions of ORS 750.301 to 750.341.

26 **SECTION 32.** ORS 750.333, as amended by section 10, chapter 388, Oregon Laws 2025, is
27 amended to read:

28 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
29 arrangement:

30 (a) ORS 705.137, 705.138 and 705.139.

31 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
32 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
33 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
34 731.992.

35 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

36 (d) ORS 734.014 to 734.440.

37 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

38 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
39 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and 743B.221*].

40 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
41 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
42 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
43 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
44 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
45 743A.252, 743A.260 and 743A.310.

1 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
2 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
3 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
4 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
5 743B.423, 743B.430, 743B.445, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601,
6 743B.607 and 743B.610.

7 (i) The following provisions of ORS chapter 744:

8 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
9 ers;

10 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

11 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

12 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

13 (2) For the purposes of this section:

14 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

15 (b) References to certificates of authority are references to certificates of multiple employer
16 welfare arrangement.

17 (c) Contributions are premiums.

18 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
19 insurance.

20 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
21 implement the provisions of ORS 750.301 to 750.341.

22 **SECTION 33.** ORS 743A.145 is amended to read:

23 743A.145. (1) As used in this section:

24 (a) "Device" means:

25 (A) An orthotic device.

26 (B) A prosthetic device.

27 (b) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot,
28 arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm,
29 hand, back or neck.

30 (c) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole
31 or in part an arm or a leg.

32 (2) All individual and group health insurance policies providing coverage for the expenses of
33 hospital, medical or surgical services or supplies shall provide coverage for devices. The coverage
34 required by this subsection includes:

35 (a) Devices that are determined to be medically necessary to restore or maintain the ability to
36 complete activities of daily living or essential job-related activities [*and that are not solely for com-
37 fort or convenience*].

38 (b) All services and supplies medically necessary for the effective use of a device, including de-
39 sign formulation, fabrication, material and component selection, measurements, fittings, static and
40 dynamic alignments and patient instruction in the use of the device.

41 (c) Replacement of a device or any part of a device, if the replacement is determined to be
42 medically necessary, based on:

43 (A) A change in the physiological condition of the insured;

44 (B) An irreparable change in the condition of the device or part of the device; or

45 (C) The device, or a part of the device, requiring repair and the cost of the repair would be more

1 than 60 percent of the cost of the replacement device or replacement part of the device.

2 (d) Repair of a device or any part of a device, if the repair is determined to be medically nec-
3 essary, based on:

4 (A) A change in the physiological condition of the insured; or

5 (B) A change in the condition of the device or part of the device.

6 (e) Devices that are determined to be medically necessary and the most appropriate model that
7 meets the medical needs of the insured for purposes of performing physical activities, including but
8 not limited to running, biking, swimming and strength training, and that maximizes the insured's
9 whole-body health, including lower and upper limb function.

10 (3) The Director of the Department of Consumer and Business Services shall adopt and annually
11 update rules listing the devices covered under this section. The list shall be no more restrictive than
12 the list of devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Pros-
13 thetics, Orthotics and Supplies, but only to the extent consistent with this section.

14 (4) The coverage required by subsection (2) of this section may be made subject to, and no more
15 restrictive than, the provisions of a health insurance policy that apply to other benefits under the
16 policy.

17 (5) If the coverage under subsection (2) of this section is provided through a managed care or-
18 ganization, the insured shall have access to medically necessary clinical care and to devices and
19 technology from not fewer than two distinct Oregon prosthetic and orthotic providers in the man-
20 aged care organization's provider network.

21 (6) An individual or group health plan may not deny coverage for a prosthetic or orthotic benefit
22 for an insured with limb loss, impairment or absence to restore or maintain the ability to perform
23 a physical activity if a benefit would be covered for medical or surgical intervention for a person
24 without limb loss, impairment or absence to restore or maintain the ability to perform the same
25 physical activity.

26 (7) For coverage described in subsection (2)(c) of this section, an insurer may require confirma-
27 tion from the prescribing health care provider that the coverage is medically necessary if the device,
28 or any part of the device, requires replacement and is less than three years old.

29 (8) This section is exempt from ORS 743A.001.

30 (9) The coverage requirements described in subsections (2)(e), (6) and (7) of this section do not
31 apply to a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Edu-
32 cators Benefit Board, unless the plans offered by the Public Employees' Benefit Board or the Oregon
33 Educators Benefit Board elect to provide the coverage and provide notice to the Department of
34 Consumer and Business Services in the form and manner described by the department by rule.

35
36 **PHARMACY**

37
38 **SECTION 34.** ORS 744.702 is amended to read:

39 744.702. (1) Subject to ORS 744.704, a person shall not transact business or purport or offer to
40 transact business as a third party administrator in this state unless the person holds a third party
41 administrator license issued by the Director of the Department of Consumer and Business Services.

42 (2) For purposes of ORS 744.700 to 744.740, a person transacts or purports or offers to transact
43 business as a third party administrator if the person:

44 (a) Directly or indirectly solicits or effects coverage of, underwrites, collects charges or premi-
45 ums from, or adjusts or settles claims on, residents of this state or residents of another state from

1 offices in this state, in connection with life insurance or health insurance coverage; or

2 (b) Acts as a pharmacy services administrative organization, as defined in ORS 735.538, or as
3 an organization that advises or represents pharmacies that are members of the organization, or that
4 enters into contracts on behalf of members, in matters that are related to procuring or supplying
5 prescription drugs.

6 (3) A pharmacy services administrative organization, as defined in ORS 735.538, is exempt from
7 the requirement to obtain a license under [ORS 735.538] **subsection (2) of this section**, if the
8 pharmacy services administrative organization is not owned by a pharmacy benefit manager and
9 generates revenue only from monthly service fees that a pharmacy pays for services that are not
10 connected to drug pricing or volume.

11 (4) Nothing in ORS 744.700 to 744.740 exempts a third party administrator from any other ap-
12 plicable licensing requirement when the third party administrator performs the functions of an in-
13 surance producer, adjuster or insurance consultant.

14 **SECTION 35.** ORS 646A.694 is amended to read:

15 646A.694. (1) The Department of Consumer and Business Services shall provide to the Pre-
16 scription Drug Affordability Board each calendar year a list of prescription drugs included in re-
17 ports submitted to the department under ORS 646A.689 (2) and (6), a list of drugs included in reports
18 submitted to the department under ORS 646A.683 and 743.025 and a list of insulin drugs marketed
19 in this state during the previous calendar year. Each calendar year, the board shall identify up to
20 nine drugs and **may identify** at least one insulin product from the lists provided under this sub-
21 section that the board determines may create affordability challenges for health care systems or
22 high out-of-pocket costs for patients in this state based on criteria adopted by the board by rule,
23 including but not limited to:

24 (a) Whether the prescription drug has led to health inequities in communities of color;

25 (b) The number of residents in this state prescribed the prescription drug;

26 (c) The price for the prescription drug sold in this state;

27 (d) The estimated average monetary price concession, discount or rebate the manufacturer pro-
28 vides to health insurance plans in this state or is expected to provide to health insurance plans in
29 this state, expressed as a percentage of the price for the prescription drug under review;

30 (e) The estimated total amount of the price concession, discount or rebate the manufacturer
31 provides to each pharmacy benefit manager licensed in this state for the prescription drug under
32 review, expressed as a percentage of the prices;

33 (f) The estimated price for therapeutic alternatives to the drug that are sold in this state;

34 (g) The estimated average price concession, discount or rebate the manufacturer provides or is
35 expected to provide to health insurance plans and pharmacy benefit managers in this state for
36 therapeutic alternatives;

37 (h) The estimated costs to health insurance plans based on patient use of the drug consistent
38 with the labeling approved by the United States Food and Drug Administration and recognized
39 standard medical practice;

40 (i) The impact on patient access to the drug considering standard prescription drug benefit de-
41 signs in health insurance plans offered in this state;

42 (j) The relative financial impacts to health, medical or social services costs as can be quantified
43 and compared to the costs of existing therapeutic alternatives;

44 (k) The estimated average patient copayment or other cost-sharing for the prescription drug in
45 this state;

1 (L) Any information a manufacturer chooses to provide; and

2 (m) Any other factors as determined by the board in rules adopted by the board.

3 (2) A drug that is designated by the Secretary of the United States Food and Drug Adminis-
4 tration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition is not subject to review
5 under subsection (1) of this section.

6 (3) The board shall accept testimony from patients and caregivers affected by a condition or
7 disease that is treated by a prescription drug under review by the board and from individuals with
8 scientific or medical training with respect to the disease or condition.

9 (4)(a) If the board considers the cost-effectiveness of a prescription drug in criteria adopted by
10 the board under subsection (1) of this section, the board may not use quality-adjusted life-years, or
11 similar formulas that take into account a patient's age or severity of illness or disability, to identify
12 subpopulations for which a prescription drug would be less cost-effective. For any prescription drug
13 that extends life, the board's analysis of cost-effectiveness must weigh the value of the quality of life
14 equally for all patients, regardless of the patients' age or severity of illness or disability.

15 (b) As used in this subsection:

16 (A) "Health utility" means a measure of the degree to which having a particular form of disease
17 or disability or having particular functional limitations negatively impacts the quality of life as
18 compared to a state of perfect health, expressed as a number between zero and one.

19 (B) "Quality-adjusted life-year" is the product of a health utility multiplied by the extra months
20 or years of life that a patient might gain as a result of a treatment.

21 (5) To the extent practicable, the board shall access pricing information for prescription drugs
22 by:

23 (a) Accessing pricing information collected by the department under ORS 646A.689 and 743.025;

24 (b) Accessing data reported to the Oregon Health Authority under ORS 442.373;

25 (c) Entering into a memorandum of understanding with another state to which manufacturers
26 already report pricing information; and

27 (d) Accessing other publicly available pricing information.

28 (6) The information used to conduct an affordability review may include any document and re-
29 search related to the introductory price or price increase of a prescription drug, including life cycle
30 management, net average price in this state, market competition and context, projected revenue and
31 the estimated value or cost-effectiveness of the prescription drug.

32 (7) The department and the board shall keep strictly confidential any information collected, used
33 or relied upon for the review conducted under this section if the information is:

34 (a) Information submitted to the department by a manufacturer under ORS 646A.689; and

35 (b) Confidential, proprietary or a trade secret as defined in ORS 192.345.

36
37 **PSILOCYBIN**

38
39 **SECTION 36.** ORS 475A.325 is amended to read:

40 475A.325. *[Facilitator license; fees; rules.]* (1) The facilitation of psilocybin services is subject to
41 regulation by the Oregon Health Authority.

42 (2) A psilocybin service facilitator must have a facilitator license issued by the authority. To
43 hold a facilitator license issued under this section, a psilocybin service facilitator **shall**:

44 (a) *[Must]* Apply for a license in the manner described in ORS 475A.245;

45 (b) *[Must]* Provide proof that the applicant is 21 years of age or older;

1 [(c) *Must, until January 1, 2025, provide proof that the applicant has been a resident of this state*
2 *for two or more years;*]

3 [(d)] (c) [*Must*] Have a high school diploma or equivalent education;

4 [(e)] (d) [*Must*] Submit evidence of completion of education and training prescribed and approved
5 by the authority;

6 [(f)] (e) [*Must*] Have passed an examination approved, administered or recognized by the au-
7 thority; and

8 [(g)] (f) [*Must*] Meet the requirements of any rule adopted by the authority under subsection (4)
9 of this section.

10 (3) The authority may not require a psilocybin service facilitator to have a degree from a uni-
11 versity, college, post-secondary institution[,] or other institution of higher education.

12 (4) The authority shall adopt rules that:

13 (a) Require a psilocybin service facilitator to annually renew a license issued under this section;

14 (b) Establish application, licensure and renewal of licensure fees for psilocybin service
15 facilitators; [*and*]

16 (c) Require a psilocybin service facilitator to meet any public health and safety standards and
17 industry best practices established by the authority by rule[.]; **and**

18 **(d) In order to meet the requirement described in subsection (2)(d) of this section, allow**
19 **an applicant to submit proof of completion of a psilocybin service facilitator training program**
20 **in another state if the training program is approved by the regulatory body responsible for**
21 **regulating psilocybin service facilitator training programs in that state, and the authority**
22 **determines that the training program’s curriculum meets or exceeds the standards adopted**
23 **under ORS 475A.380.**

24 (5) Fees adopted under subsection (4)(b) of this section:

25 (a) May not exceed, together with other fees collected under ORS 475A.210 to 475A.722, the cost
26 of administering ORS 475A.210 to 475A.722; and

27 (b) Shall be deposited in the Psilocybin Control and Regulation Fund established under ORS
28 475A.492.

29 (6) A psilocybin service facilitator may be, [*but need not be,*] **but is not required to be,** an
30 employee, manager, director, officer, partner, member, shareholder[,] or direct or indirect owner of
31 one or more psilocybin service center operators.

32 (7) A license issued to a psilocybin service facilitator under this section is not limited to any
33 one or more premises.

34 **SECTION 37.** ORS 475A.338 is amended to read:

35 475A.338. (1)(a) As used in this subsection, “board” means:

36 **(A) The Occupational Therapy Licensing Board;**

37 [(A)] **(B) The Oregon Board of Licensed Professional Counselors and Therapists;**

38 [(B)] **(C) The Oregon Board of Naturopathic Medicine;**

39 **(D) The Oregon Board of Physical Therapy;**

40 [(C)] **(E) The Oregon Board of Psychology;**

41 [(D)] **(F) The Oregon Medical Board;**

42 [(E)] **(G) The Oregon State Board of Nursing;**

43 [(F)] **(H) The State Board of Licensed Social Workers; and**

44 [(G)] **(I) The State Board of Pharmacy.**

45 (b) A person who is licensed or otherwise authorized by a board to provide health care or be-

1 behavioral health care services and who holds a license under ORS 475A.325 may, in accordance with
2 the provisions of ORS 475A.210 to 475A.722 and rules adopted under ORS 475A.210 to 475A.722:

3 (A) Conduct preparation sessions and integration sessions with clients in addition to and while
4 providing health care or behavioral health care services.

5 (B) Conduct administration sessions with clients, so long as the person does not provide health
6 care or behavioral health care services while providing psilocybin services.

7 (2) A health care provider, as defined in ORS 127.505, may not be subject to a civil penalty or
8 other disciplinary action by the state agency that regulates the health care provider for:

9 (a) Discussing with a client or patient, as a treatment option, psilocybin services provided by a
10 psilocybin service facilitator that holds a license issued under ORS 475A.325 at a psilocybin service
11 center for which a license is issued under ORS 475A.305; or

12 (b) If the health care provider holds a license issued under ORS 475A.325, providing psilocybin
13 services in accordance with the provisions of ORS 475A.210 to 475A.722 and rules adopted under
14 ORS 475A.210 to 475A.722, so long as the health care provider does not provide health care services
15 while providing psilocybin services.

16 **SECTION 38.** ORS 475A.372 is amended to read:

17 475A.372. (1) As used in this section, “adverse behavioral reaction” and “adverse medical re-
18 action” have the meanings given those terms by rule by the Oregon Health Authority.

19 (2) A psilocybin service center operator that holds a license issued under ORS 475A.305 shall:

20 (a) Collect and maintain the following information, in addition to the information required to
21 complete a client information form described in ORS 475A.350:

22 (A) The race, ethnicity, preferred spoken and written languages, disability status, sexual orien-
23 tation, gender identity, income, age, veteran status and county of residence of each client; and

24 (B) The reasons for which a client requests psilocybin services;

25 (b) Compile and maintain the following information that pertains to the three-month period im-
26 mediately preceding a quarterly submission under subsection (4) of this section:

27 (A) The number of clients served;

28 (B) The number of individual administration sessions provided;

29 (C) The number of group administration sessions provided;

30 (D) The number of individuals to whom the psilocybin service center or a psilocybin service
31 facilitator practicing at the psilocybin service center denied psilocybin services and the reasons for
32 which psilocybin services were denied;

33 (E) The number and severity of:

34 (i) Adverse behavioral reactions experienced by clients, of which the psilocybin service center
35 operator is aware; and

36 (ii) Adverse medical reactions experienced by clients, of which the psilocybin service center
37 operator is aware; and

38 (F) Any additional information required by the authority by rule as described in subsection (7)
39 of this section; and

40 (c) Compute, for the period described in paragraph (b) of this subsection, and maintain the fol-
41 lowing information:

42 (A) The average number of times per client that psilocybin services were received;

43 (B) The average number of clients participating in each group administration session; *[and]*

44 (C) **For doses higher than five milligrams of psilocybin analyte, the total average dose of**
45 **psilocybin per client per administration session[.]; and**

1 stored by the board upon receipt, not more than 30 days after the license lapses, of a completed
2 renewal application and payment of the restoration fee under subsection (8) of this section.

3 (4) A license that has lapsed for more than one month may be restored by the board upon pay-
4 ment of the restoration fee established by the board and submission of a completed renewal appli-
5 cation and any other information required by the board.

6 (5) A person holding an active license under this chapter may convert the license to inactive
7 status by meeting the requirements set by rule of the board and paying any required fees. A person
8 holding a license issued under this chapter who is at least [70] 65 years of age and retired from the
9 practice of naturopathic medicine may convert the license to retired status by meeting the require-
10 ments set by rule of the board and paying any required fees.

11 (6)(a) A person who chooses to allow a license to become inactive may file a written application
12 to reactivate a license that has been inactive for one year or less by paying the restoration fee and
13 the renewal fee for an active license and demonstrating compliance with ORS 685.102. A fee paid
14 to place the license in inactive status may not be credited toward payment of the renewal fee for
15 an active license. The board may prorate the renewal fee.

16 (b) A person who chooses to allow a license to become inactive may file a written application
17 to reactivate a license that has been inactive for more than one year by paying the renewal fee for
18 an active license and demonstrating compliance with the continuing education requirement set by
19 rule of the board under ORS 685.102 (6). The board may prorate the renewal fee.

20 (7) The executive director of the board shall issue a renewal notice to each person holding a
21 license under this chapter at least 60 days before the renewal application is due.

22 (8) The board shall assess fees for:

23 (a) An initial license.

24 (b) Examination.

25 (c) Renewal of an active license.

26 (d) Yearly renewal of an inactive or retired license.

27 (e) Restoration of an inactive, lapsed or revoked license.

28 (f) A certificate of special competency in natural childbirth.

29 (g) A duplicate license.

30 (h) A wall certificate.

31 (i) Copies of public documents, mailing labels, lists and diskettes.

32 (9) Subject to prior approval of the Oregon Department of Administrative Services, the fees and
33 charges established under this section may not exceed the cost of administering the regulatory
34 program of the [board] **Oregon Board of Naturopathic Medicine** pertaining to the purpose for
35 which the fee or charge is established, as authorized by the Legislative Assembly within the board's
36 budget, as the budget may be modified by the Emergency Board.

37 **SECTION 41.** ORS 685.102 is amended to read:

38 685.102. (1) Except as provided in subsections (2) and (5) of this section, each person holding a
39 license under this chapter shall submit annually by December 31, evidence satisfactory to the
40 Oregon Board of Naturopathic Medicine of successful completion of an approved program of con-
41 tinuing education of at least 25 hours in naturopathic medicine, completed in the calendar year
42 preceding the date on which the evidence is submitted, and completion during the renewal period,
43 or documentation of completion within the previous 36 months, of:

44 (a) A pain management education program approved by the board and developed based on rec-
45 ommendations of the Pain Management Commission; or

1 (b) An equivalent pain management education program, as determined by the board.

2 (2) The board may exempt any person holding a license under this chapter from the require-
3 ments of subsection (1) of this section upon application showing evidence satisfactory to the board
4 of inability to comply with the requirements because of physical or mental condition or because of
5 other unusual or extenuating circumstances. However, a person may not be exempted from the re-
6 quirements of subsection (1) of this section more than once in any five-year period.

7 (3) Notwithstanding subsection (2) of this section, a person holding a license under this chapter
8 may be exempted from the requirements of subsection (1) of this section upon application showing
9 evidence satisfactory to the board that the applicant is or will be in the next calendar year at least
10 [70] 65 years of age and is retired or will retire in the next calendar year from the practice of
11 naturopathic medicine.

12 (4) The board shall require licensees to obtain continuing education for the use of
13 pharmacological substances for diagnostic, preventive and therapeutic purposes in order to maintain
14 current licensure.

15 (5) A person whose license is in inactive status must submit by December 31 of each year evi-
16 dence satisfactory to the board of completion of 10 hours of approved continuing education in the
17 calendar year preceding the date on which the evidence is submitted.

18 (6) Notwithstanding subsections (1), (2) and (5) of this section, in the case of an applicant under
19 ORS 685.100 (6)(b) for reactivation of an inactive license, the continuing education requirement for
20 reactivation shall be set by rule of the board.

21 **SECTION 42.** (1) **The amendments to ORS 685.100 and 685.102 by sections 40 and 41 of this**
22 **2026 Act become operative on January 1, 2027.**

23 **(2) The Oregon Board of Naturopathic Medicine may take any action before the operative**
24 **date specified in subsection (1) of this section that is necessary to enable the board to exer-**
25 **cise, on and after the operative date specified in subsection (1) of this section, all of the du-**
26 **ties, functions and powers conferred on the board by the amendments to ORS 685.100 and**
27 **685.102 by sections 40 and 41 of this 2026 Act.**

28
29 **WORKERS' COMPENSATION RECLASSIFICATION OF**
30 **PHYSICIAN ASSOCIATES AND NURSE PRACTITIONERS**
31

32 **SECTION 43.** ORS 656.005 is amended to read:

33 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
34 ployment, as determined by the Employment Department, for the last quarter of the calendar year
35 preceding the fiscal year in which the injury occurred.

36 (2)(a) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent
37 of a worker, who is entitled to receive payments under this chapter.

38 (b) "Beneficiary" does not include a person who intentionally causes the compensable injury to
39 or death of an injured worker.

40 (3) "Board" means the Workers' Compensation Board.

41 (4) "Carrier-insured employer" means an employer who provides workers' compensation cover-
42 age with the State Accident Insurance Fund Corporation or an insurer authorized under ORS
43 chapter 731 to transact workers' compensation insurance in this state.

44 (5) "Child" means a child of an injured worker, including:

45 (a) A posthumous child;

1 (b) A child legally adopted before the injury;

2 (c) A child toward whom the worker stands in loco parentis;

3 (d) A child born out of wedlock;

4 (e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker's family
5 and substantially dependent upon the worker for support; and

6 (f) A child of any age who was incapacitated at the time of the accident and thereafter remains
7 incapacitated and substantially dependent on the worker for support.

8 (6) "Claim" means a written request for compensation from a subject worker or someone on the
9 worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

10 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
11 ances, arising out of and in the course of employment requiring medical services or resulting in
12 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-
13 dental means, if it is established by medical evidence supported by objective findings, subject to the
14 following limitations:

15 (A) An injury or disease is not compensable as a consequence of a compensable injury unless
16 the compensable injury is the major contributing cause of the consequential condition.

17 (B) If an otherwise compensable injury combines at any time with a preexisting condition to
18 cause or prolong disability or a need for treatment, the combined condition is compensable only if,
19 so long as and to the extent that the otherwise compensable injury is the major contributing cause
20 of the disability of the combined condition or the major contributing cause of the need for treatment
21 of the combined condition.

22 (b) "Compensable injury" does not include:

23 (A) Injury to any active participant in assaults or combats that are not connected to the job
24 assignment and that amount to a deviation from customary duties;

25 (B) Injury incurred while engaging in or performing, or as the result of engaging in or per-
26 forming, any recreational or social activities primarily for the worker's personal pleasure; or

27 (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
28 the evidence the injured worker's consumption of alcoholic beverages or cannabis or the unlawful
29 consumption of any controlled substance, unless the employer permitted, encouraged or had actual
30 knowledge of such consumption.

31 (c) A "disabling compensable injury" is an injury that entitles the worker to compensation for
32 disability or death. An injury is not disabling if no temporary benefits are due and payable, unless
33 there is a reasonable expectation that permanent disability will result from the injury.

34 (d) A "nondisabling compensable injury" is any injury that requires medical services only.

35 (8) "Compensation" includes all benefits, including medical services, provided for a compensable
36 injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pur-
37 suant to this chapter.

38 (9) "Department" means the Department of Consumer and Business Services.

39 (10) "Dependent" means any of the following individuals who, at the time of an accident, de-
40 pended in whole or in part for the individual's support on the earnings of a worker who dies as a
41 result of an injury:

42 (a) A parent of a worker or the parent's spouse or domestic partner;

43 (b) A grandparent of a worker or the grandparent's spouse or domestic partner;

44 (c) A grandchild of a worker or the grandchild's spouse or domestic partner;

45 (d) A sibling or stepsibling of a worker or the sibling's or stepsibling's spouse or domestic

1 partner; and

2 (e) Any individual related by blood or affinity whose close association with a worker is the
3 equivalent of a family relationship.

4 (11) "Director" means the Director of the Department of Consumer and Business Services.

5 (12)(a) [*“Doctor” or “physician”*] **“Doctor,” “physician,” “nurse practitioner” or “physician**
6 **associate”** means a person duly licensed to practice one or more of the healing arts in any country
7 or in any state, territory or possession of the United States within the limits of the license of the
8 licensee.

9 (b) Except as otherwise provided for workers subject to a managed care contract, “attending
10 physician” means a doctor, physician, **nurse practitioner** or physician associate who is primarily
11 responsible for the treatment of a worker’s compensable injury and who is:

12 [(A) *A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a*
13 *podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board,*
14 *an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
15 *doctor in any country or in any state, territory or possession of the United States;]*

16 **(A)(i) A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board or**
17 **a similarly licensed physician in any country or in any state, territory or possession of the**
18 **United States;**

19 **(ii) A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon**
20 **Medical Board or a similarly licensed physician and surgeon in any country or in any state,**
21 **territory or possession of the United States;**

22 **(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a**
23 **similarly licensed surgeon in any country or in any state, territory or possession of the**
24 **United States;**

25 **(iv) A nurse practitioner licensed under ORS 678.375 to 678.390 or a similarly licensed**
26 **nurse practitioner in any country or in any state, territory or possession of the United**
27 **States; or**

28 **(v) A physician associate licensed by the Oregon Medical Board in accordance with ORS**
29 **677.505 to 677.525 or a similarly licensed physician associate in any country or in any state,**
30 **territory or possession of the United States; or**

31 (B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative
32 total of 18 visits, whichever occurs first, to any of the medical service providers listed in this sub-
33 paragraph, a:

34 (i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of
35 Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any
36 state, territory or possession of the United States; or

37 (ii) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of
38 Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any
39 country or in any state, territory or possession of the United States.[: or]

40 [(C) *For a cumulative total of 180 days from the first visit on the initial claim, a physician associate*
41 *licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly li-*
42 *icensed physician associate in any country or in any state, territory or possession of the United*
43 *States.]*

44 (c) Except as otherwise provided for workers subject to a managed care contract, “attending
45 physician” does not include a physician who provides care in a hospital emergency room and refers

1 the injured worker to a primary care physician for follow-up care and treatment.

2 (d) "Consulting physician" means a doctor or physician who examines a worker or the worker's
3 medical record to advise the attending physician [*or nurse practitioner authorized to provide*
4 *compensable medical services under ORS 656.245*] regarding treatment of a worker's compensable
5 injury.

6 (13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and
7 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
8 rations or political subdivisions, that contracts to pay a remuneration for the services of any
9 worker.

10 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
11 a temporary service provider is not the employer of temporary workers provided by the temporary
12 service provider.

13 (c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning
14 given that term in ORS 656.850.

15 (d) For the purposes of this chapter, "subject employer" means an employer that is subject to
16 this chapter as provided in ORS 656.023.

17 (14) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized
18 under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned
19 claims agent selected by the director under ORS 656.054.

20 (15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.

21 (16) "Incapacitated" means an individual is physically or mentally unable to earn a livelihood.

22 (17) "Medically stationary" means that no further material improvement would reasonably be
23 expected from medical treatment or the passage of time.

24 (18) "Noncomplying employer" means a subject employer that has failed to comply with ORS
25 656.017.

26 (19) "Objective findings" in support of medical evidence are verifiable indications of injury or
27 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
28 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
29 sponses to physical examinations that are not reproducible, measurable or observable.

30 (20) "Palliative care" means medical service rendered to reduce or moderate temporarily the
31 intensity of an otherwise stable medical condition, but does not include those medical services ren-
32 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

33 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
34 of injury and the insurer, if any, of the employer.

35 (22) "Payroll" means a record of wages payable to workers for their services and includes
36 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
37 similar advantage received from the employer. However, "payroll" does not include overtime pay,
38 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
39 to reward workers for safe working practices. Bonus pay is limited to payments that are not antic-
40 ipated under the contract of employment and that are paid at the sole discretion of the employer.
41 The exclusion from payroll of bonus payments to reward workers for safe working practices is only
42 for the purpose of calculations based on payroll to determine premium for workers' compensation
43 insurance, and does not affect any other calculation or determination based on payroll for the pur-
44 poses of this chapter.

45 (23) "Person" includes a partnership, joint venture, association, limited liability company and

1 corporation.

2 (24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, con-
3 genital abnormality, personality disorder or similar condition that contributes to disability or need
4 for treatment, provided that:

5 (A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the
6 worker has been diagnosed with the condition, or has obtained medical services for the symptoms
7 of the condition regardless of diagnosis; and

8 (B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes
9 the initial injury;

10 (ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the
11 new medical condition; or

12 (iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment
13 precedes the onset of the worsened condition.

14 (b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, con-
15 genital abnormality, personality disorder or similar condition that contributes to disability or need
16 for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim
17 for worsening in such claims pursuant to ORS 656.273 or 656.278.

18 (c) For the purposes of industrial injury claims, a condition does not contribute to disability or
19 need for treatment if the condition merely renders the worker more susceptible to the injury.

20 (25) "Self-insured employer" means an employer or group of employers certified under ORS
21 656.430 as meeting the qualifications set out by ORS 656.407.

22 (26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident
23 Insurance Fund Corporation created under ORS 656.752.

24 (27) "Wages" means the money rate at which the service rendered is recompensed under the
25 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
26 housing, lodging or similar advantage received from the employer, and includes the amount of tips
27 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
28 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
29 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
30 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
31 which any worker shall be carried upon the payroll of the employer for the purpose of determining
32 the premium of the employer.

33 (28)(a) "Worker" means any person, other than an independent contractor, who engages to fur-
34 nish services for a remuneration, including a minor whether lawfully or unlawfully employed and
35 salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts
36 and other public corporations, but does not include any person whose services are performed as an
37 adult in custody or ward of a state institution or as part of the eligibility requirements for a general
38 or public assistance grant.

39 (b) For the purpose of determining entitlement to temporary disability benefits or permanent
40 total disability benefits under this chapter, "worker" does not include a person who has withdrawn
41 from the workforce during the period for which such benefits are sought.

42 (c) For the purposes of this chapter, "subject worker" means a worker who is subject to this
43 chapter as provided in ORS 656.027.

44 (29) "Independent contractor" has the meaning given that term in ORS 670.600.

45 **SECTION 44.** ORS 656.005, as amended by section 22, chapter 78, Oregon Laws 2025, is

1 amended to read:

2 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
3 ployment, as determined by the Employment Department, for the last quarter of the calendar year
4 preceding the fiscal year in which the injury occurred.

5 (2)(a) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent
6 of a worker, who is entitled to receive payments under this chapter.

7 (b) "Beneficiary" does not include a person who intentionally causes the compensable injury to
8 or death of an injured worker.

9 (3) "Board" means the Workers' Compensation Board.

10 (4) "Carrier-insured employer" means an employer who provides workers' compensation cover-
11 age with the State Accident Insurance Fund Corporation or an insurer authorized under ORS
12 chapter 731 to transact workers' compensation insurance in this state.

13 (5) "Child" means a child of an injured worker, including:

14 (a) A posthumous child;

15 (b) A child legally adopted before the injury;

16 (c) A child toward whom the worker stands in loco parentis;

17 (d) A child born out of wedlock;

18 (e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker's family
19 and substantially dependent upon the worker for support; and

20 (f) A child of any age who was incapacitated at the time of the accident and thereafter remains
21 incapacitated and substantially dependent on the worker for support.

22 (6) "Claim" means a written request for compensation from a subject worker or someone on the
23 worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

24 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
25 ances, arising out of and in the course of employment requiring medical services or resulting in
26 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-
27 dental means, if it is established by medical evidence supported by objective findings, subject to the
28 following limitations:

29 (A) An injury or disease is not compensable as a consequence of a compensable injury unless
30 the compensable injury is the major contributing cause of the consequential condition.

31 (B) If an otherwise compensable injury combines at any time with a preexisting condition to
32 cause or prolong disability or a need for treatment, the combined condition is compensable only if,
33 so long as and to the extent that the otherwise compensable injury is the major contributing cause
34 of the disability of the combined condition or the major contributing cause of the need for treatment
35 of the combined condition.

36 (b) "Compensable injury" does not include:

37 (A) Injury to any active participant in assaults or combats that are not connected to the job
38 assignment and that amount to a deviation from customary duties;

39 (B) Injury incurred while engaging in or performing, or as the result of engaging in or per-
40 forming, any recreational or social activities primarily for the worker's personal pleasure; or

41 (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
42 the evidence the injured worker's consumption of alcoholic beverages or cannabis or the unlawful
43 consumption of any controlled substance, unless the employer permitted, encouraged or had actual
44 knowledge of such consumption.

45 (c) A "disabling compensable injury" is an injury that entitles the worker to compensation for

1 disability or death. An injury is not disabling if no temporary benefits are due and payable, unless
2 there is a reasonable expectation that permanent disability will result from the injury.

3 (d) A “nondisabling compensable injury” is any injury that requires medical services only.

4 (8) “Compensation” includes all benefits, including medical services, provided for a compensable
5 injury to a subject worker or the worker’s beneficiaries by an insurer or self-insured employer pur-
6 suant to this chapter.

7 (9) “Department” means the Department of Consumer and Business Services.

8 (10) “Dependent” means any of the following individuals who, at the time of an accident, de-
9 pended in whole or in part for the individual’s support on the earnings of a worker who dies as a
10 result of an injury:

11 (a) A parent of a worker or the parent’s spouse or domestic partner;

12 (b) A grandparent of a worker or the grandparent’s spouse or domestic partner;

13 (c) A grandchild of a worker or the grandchild’s spouse or domestic partner;

14 (d) A sibling or stepsibling of a worker or the sibling’s or stepsibling’s spouse or domestic
15 partner; and

16 (e) Any individual related by blood or affinity whose close association with a worker is the
17 equivalent of a family relationship.

18 (11) “Director” means the Director of the Department of Consumer and Business Services.

19 (12)(a) [*“Doctor” or “physician”*] **“Doctor,” “physician,” “nurse practitioner” or “physician**
20 **associate”** means a person duly licensed to practice one or more of the healing arts in any country
21 or in any state, territory or possession of the United States within the limits of the license of the
22 licensee.

23 (b) Except as otherwise provided for workers subject to a managed care contract, “attending
24 physician” means a doctor, physician, **nurse practitioner** or physician associate who is primarily
25 responsible for the treatment of a worker’s compensable injury and who is:

26 [*A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a*
27 *podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board,*
28 *an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
29 *doctor in any country or in any state, territory or possession of the United States;]*

30 **(A)(i) A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board or**
31 **a similarly licensed physician in any country or in any state, territory or possession of the**
32 **United States;**

33 **(ii) A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon**
34 **Medical Board or a similarly licensed physician and surgeon in any country or in any state,**
35 **territory or possession of the United States;**

36 **(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a**
37 **similarly licensed surgeon in any country or in any state, territory or possession of the**
38 **United States;**

39 **(iv) A nurse practitioner licensed under ORS 678.375 to 678.390 or a similarly licensed**
40 **nurse practitioner in any country or in any state, territory or possession of the United**
41 **States; or**

42 **(v) A physician associate licensed by the Oregon Medical Board in accordance with ORS**
43 **677.505 to 677.525 or a similarly licensed physician associate in any country or in any state,**
44 **territory or possession of the United States; or**

45 (B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative

1 total of 18 visits, whichever occurs first, to any of the medical service providers listed in this sub-
2 paragraph, a:

3 (i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of
4 Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any
5 state, territory or possession of the United States; or

6 (ii) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of
7 Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any
8 country or in any state, territory or possession of the United States.]; *or*]

9 [(C) *For a cumulative total of 180 days from the first visit on the initial claim, a physician associate*
10 *licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly li-*
11 *icensed physician associate in any country or in any state, territory or possession of the United*
12 *States.*]

13 (c) Except as otherwise provided for workers subject to a managed care contract, “attending
14 physician” does not include a physician who provides care in a hospital emergency room and refers
15 the injured worker to a primary care physician for follow-up care and treatment.

16 (d) “Consulting physician” means a doctor or physician who examines a worker or the worker’s
17 medical record to advise the attending physician [*or nurse practitioner authorized to provide*
18 *compensable medical services under ORS 656.245*] regarding treatment of a worker’s compensable
19 injury.

20 (13)(a) “Employer” means any person, including receiver, administrator, executor or trustee, and
21 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
22 rations or political subdivisions, that contracts to pay a remuneration for the services of any
23 worker.

24 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
25 a temporary service provider is not the employer of temporary workers provided by the temporary
26 service provider.

27 (c) As used in paragraph (b) of this subsection, “temporary service provider” has the meaning
28 given that term in ORS 656.849.

29 (d) For the purposes of this chapter, “subject employer” means an employer that is subject to
30 this chapter as provided in ORS 656.023.

31 (14) “Insurer” means the State Accident Insurance Fund Corporation or an insurer authorized
32 under ORS chapter 731 to transact workers’ compensation insurance in this state or an assigned
33 claims agent selected by the director under ORS 656.054.

34 (15) “Consumer and Business Services Fund” means the fund created by ORS 705.145.

35 (16) “Incapacitated” means an individual is physically or mentally unable to earn a livelihood.

36 (17) “Medically stationary” means that no further material improvement would reasonably be
37 expected from medical treatment or the passage of time.

38 (18) “Noncomplying employer” means a subject employer that has failed to comply with ORS
39 656.017.

40 (19) “Objective findings” in support of medical evidence are verifiable indications of injury or
41 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
42 palpable muscle spasm. “Objective findings” does not include physical findings or subjective re-
43 sponses to physical examinations that are not reproducible, measurable or observable.

44 (20) “Palliative care” means medical service rendered to reduce or moderate temporarily the
45 intensity of an otherwise stable medical condition, but does not include those medical services ren-

1 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

2 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
3 of injury and the insurer, if any, of the employer.

4 (22) "Payroll" means a record of wages payable to workers for their services and includes
5 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
6 similar advantage received from the employer. However, "payroll" does not include overtime pay,
7 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
8 to reward workers for safe working practices. Bonus pay is limited to payments that are not antic-
9 ipated under the contract of employment and that are paid at the sole discretion of the employer.
10 The exclusion from payroll of bonus payments to reward workers for safe working practices is only
11 for the purpose of calculations based on payroll to determine premium for workers' compensation
12 insurance, and does not affect any other calculation or determination based on payroll for the pur-
13 poses of this chapter.

14 (23) "Person" includes a partnership, joint venture, association, limited liability company and
15 corporation.

16 (24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, con-
17 genital abnormality, personality disorder or similar condition that contributes to disability or need
18 for treatment, provided that:

19 (A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the
20 worker has been diagnosed with the condition, or has obtained medical services for the symptoms
21 of the condition regardless of diagnosis; and

22 (B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes
23 the initial injury;

24 (ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the
25 new medical condition; or

26 (iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment
27 precedes the onset of the worsened condition.

28 (b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, con-
29 genital abnormality, personality disorder or similar condition that contributes to disability or need
30 for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim
31 for worsening in such claims pursuant to ORS 656.273 or 656.278.

32 (c) For the purposes of industrial injury claims, a condition does not contribute to disability or
33 need for treatment if the condition merely renders the worker more susceptible to the injury.

34 (25) "Self-insured employer" means an employer or group of employers certified under ORS
35 656.430 as meeting the qualifications set out by ORS 656.407.

36 (26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident
37 Insurance Fund Corporation created under ORS 656.752.

38 (27) "Wages" means the money rate at which the service rendered is recompensed under the
39 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
40 housing, lodging or similar advantage received from the employer, and includes the amount of tips
41 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
42 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
43 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
44 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
45 which any worker shall be carried upon the payroll of the employer for the purpose of determining

1 the premium of the employer.

2 (28)(a) "Worker" means any person, other than an independent contractor, who engages to fur-
3 nish services for a remuneration, including a minor whether lawfully or unlawfully employed and
4 salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts
5 and other public corporations, but does not include any person whose services are performed as an
6 adult in custody or ward of a state institution or as part of the eligibility requirements for a general
7 or public assistance grant.

8 (b) For the purpose of determining entitlement to temporary disability benefits or permanent
9 total disability benefits under this chapter, "worker" does not include a person who has withdrawn
10 from the workforce during the period for which such benefits are sought.

11 (c) For the purposes of this chapter, "subject worker" means a worker who is subject to this
12 chapter as provided in ORS 656.027.

13 (29) "Independent contractor" has the meaning given that term in ORS 670.600.

14 **SECTION 45.** ORS 656.214 is amended to read:

15 656.214. (1) As used in this section:

16 (a) "Impairment" means the loss of use or function of a body part or system due to the
17 compensable industrial injury or occupational disease determined in accordance with the standards
18 provided under ORS 656.726, expressed as a percentage of the whole person.

19 (b) "Loss" includes permanent and complete or partial loss of use.

20 (c) "Permanent partial disability" means:

21 (A) Permanent impairment resulting from the compensable industrial injury or occupational
22 disease; or

23 (B) Permanent impairment and work disability resulting from the compensable industrial injury
24 or occupational disease.

25 (d) "Regular work" means the job the worker held at injury.

26 (e) "Work disability" means impairment modified by age, education and adaptability to perform
27 a given job.

28 (2) When permanent partial disability results from a compensable injury or occupational disease,
29 benefits shall be awarded as follows:

30 (a) If the worker has been released to regular work by the attending physician [*or nurse prac-*
31 *titioner authorized to provide compensable medical services under ORS 656.245*] or has returned to
32 regular work [*at the job held at the time of injury*], the award shall be for impairment only. Impair-
33 ment shall be determined in accordance with the standards provided by the Director of the Depart-
34 ment of Consumer and Business Services pursuant to ORS 656.726 (4). Impairment benefits are
35 determined by multiplying the impairment value times 100 times the average weekly wage as defined
36 by ORS 656.005.

37 (b) If the worker has not been released to regular work by the attending physician [*or nurse*
38 *practitioner authorized to provide compensable medical services under ORS 656.245*] or has not re-
39 turned to regular work [*at the job held at the time of injury*], the award shall be for impairment and
40 work disability. Work disability shall be determined in accordance with the standards provided by
41 the director pursuant to ORS 656.726 (4). Impairment shall be determined as provided in paragraph
42 (a) of this subsection. Work disability benefits shall be determined by multiplying the impairment
43 value, as modified by the factors of age, education and adaptability to perform a given job, times
44 150 times the worker's weekly wage for the job at injury as calculated under ORS 656.210 (2). The
45 factor for the worker's weekly wage used for the determination of the work disability may be no

1 more than 133 percent or no less than 50 percent of the average weekly wage as defined in ORS
2 656.005.

3 (3) Impairment benefits awarded under subsection (2)(a) of this section shall be expressed as a
4 percentage of the whole person. Impairment benefits for the following body parts may not exceed:

5 (a) For the loss of one arm at or above the elbow joint, 60 percent.

6 (b) For the loss of one forearm at or above the wrist joint, or the loss of one hand, 47 percent.

7 (c) For the loss of one leg, at or above the knee joint, 47 percent.

8 (d) For the loss of one foot, 42 percent.

9 (e) For the loss of a great toe, six percent; for loss of any other toe, one percent.

10 (f) For partial or complete loss of hearing in one ear, that proportion of 19 percent which the
11 loss bears to normal monaural hearing.

12 (g) For partial or complete loss of hearing in both ears, that proportion of 60 percent which the
13 combined binaural hearing loss bears to normal combined binaural hearing. For the purpose of this
14 paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss
15 in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount
16 by eight. In the case of individuals with compensable hearing loss involving both ears, either the
17 method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be
18 used, depending upon which allows the greater award of impairment.

19 (h) For partial or complete loss of vision of one eye, that proportion of 31 percent which the loss
20 of monocular vision bears to normal monocular vision. For the purposes of this paragraph, the term
21 "normal monocular vision" shall be considered as Snellen 20/20 for distance and Snellen 14/14 for
22 near vision with full sensory field.

23 (i) For partial loss of vision in both eyes, that proportion of 94 percent which the combined
24 binocular visual loss bears to normal combined binocular vision. In all cases of partial loss of sight,
25 the percentage of said loss shall be measured with maximum correction. For the purpose of this
26 paragraph, combined binocular visual loss shall be calculated by taking three times the visual loss
27 in the less damaged eye plus the visual loss in the more damaged eye and dividing that amount by
28 four. In the case of individuals with compensable visual loss involving both eyes, either the method
29 of calculation for monocular visual loss or that for combined binocular visual loss shall be used,
30 depending upon which allows the greater award of impairment.

31 (j) For the loss of a thumb, 15 percent.

32 (k) For the loss of a first finger, eight percent; of a second finger, seven percent; of a third fin-
33 ger, three percent; of a fourth finger, two percent.

34 (4) The loss of one phalange of a thumb, including the adjacent epiphyseal region of the proximal
35 phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange of a finger,
36 including the adjacent epiphyseal region of the middle phalange, is considered equal to the loss of
37 one-half of a finger. The loss of two phalanges of a finger, including the adjacent epiphyseal region
38 of the proximal phalange of a finger, is considered equal to the loss of 75 percent of a finger. The
39 loss of more than one phalange of a thumb, excluding the epiphyseal region of the proximal
40 phalange, is considered equal to the loss of an entire thumb. The loss of more than two phalanges
41 of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is considered equal
42 to the loss of an entire finger. A proportionate loss of use may be allowed for an uninjured finger
43 or thumb where there has been a loss of effective opposition.

44 (5) A proportionate loss of the hand may be allowed where impairment extends to more than one
45 digit, in lieu of ratings on the individual digits.

1 (6) All permanent disability contemplates future waxing and waning of symptoms of the condi-
2 tion. The results of waxing and waning of symptoms may include, but are not limited to, loss of
3 earning capacity, periods of temporary total or temporary partial disability, or inpatient
4 hospitalization.

5 **SECTION 46.** ORS 656.245 is amended to read:

6 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
7 to be provided medical services for conditions caused in material part by the injury for such period
8 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
9 656.225, including such medical services as may be required after a determination of permanent
10 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
11 insurer or the self-insured employer shall cause to be provided only those medical services directed
12 to medical conditions caused in major part by the injury.

13 (b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances
14 and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and
15 supports and where necessary, physical restorative services. A pharmacist or dispensing physician
16 shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide
17 such medical services continues for the life of the worker.

18 (c) Notwithstanding any other provision of this chapter, medical services after the worker's
19 condition is medically stationary are not compensable except for the following:

20 (A) Services provided to a worker who has been determined to be permanently and totally dis-
21 abled.

22 (B) Prescription medications.

23 (C) Services necessary to administer prescription medication or monitor the administration of
24 prescription medication.

25 (D) Prosthetic devices, braces and supports.

26 (E) Services necessary to monitor the status, replacement or repair of prosthetic devices, braces
27 and supports.

28 (F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.

29 (G) Services provided pursuant to an order issued under ORS 656.278.

30 (H) Services that are necessary to diagnose the worker's condition.

31 (I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.

32 (J) With the approval of the insurer or self-insured employer, palliative care that the worker's
33 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
34 the worker to continue current employment or a vocational training program. If the insurer or
35 self-insured employer does not approve, the attending physician or the worker may request approval
36 from the Director of the Department of Consumer and Business Services for such treatment. The
37 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
38 (3) to aid in the review of such treatment. The decision of the director is subject to review under
39 ORS 656.704.

40 (K) With the approval of the director, curative care arising from a generally recognized, non-
41 experimental advance in medical science since the worker's claim was closed that is highly likely
42 to improve the worker's condition and that is otherwise justified by the circumstances of the claim.
43 The decision of the director is subject to review under ORS 656.704.

44 (L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
45 of symptoms of the worker's condition.

1 (d) When the medically stationary date in a disabling claim is established by the insurer or
 2 self-insured employer and is not based on the findings of the attending physician, the insurer or
 3 self-insured employer is responsible for reimbursement to affected medical service providers for
 4 otherwise compensable services rendered until the insurer or self-insured employer provides written
 5 notice to the attending physician of the worker's medically stationary status.

6 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
 7 imbursement to receive care from the attending physician [*or nurse practitioner*] authorized to pro-
 8 vide compensable medical services under this section shall not exceed the amount required to seek
 9 care from an [*appropriate nurse practitioner or*] attending physician of the same specialty who is in
 10 a medical community geographically closer to the worker's home. For the purposes of this para-
 11 graph, all **attending** physicians [*and nurse practitioners*] within a metropolitan area are considered
 12 to be part of the same medical community.

13 (2)(a) The worker may choose an attending [*doctor, physician or nurse practitioner*] **physician**
 14 within the State of Oregon. The worker may choose the initial attending physician [*or nurse practi-*
 15 *tioner*] and may subsequently change attending physician [*or nurse practitioner*] two times without
 16 approval from the director. If the worker thereafter selects another attending physician [*or nurse*
 17 *practitioner*], the insurer or self-insured employer may require the director's approval of the se-
 18 lection. The decision of the director is subject to review under ORS 656.704. The worker also may
 19 choose an attending doctor or physician in another country or in any state or territory or possession
 20 of the United States with the prior approval of the insurer or self-insured employer.

21 (b) A medical service provider who is not a member of a managed care organization is subject
 22 to the following provisions:

23 (A) A medical service provider who is not qualified to be an attending physician may provide
 24 compensable medical service to an injured worker for a period of 30 days from the date of the first
 25 visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an
 26 attending physician. Thereafter, medical service provided to an injured worker without the written
 27 authorization of an attending physician is not compensable.

28 (B) A medical service provider who is not an attending physician cannot authorize the payment
 29 of temporary disability compensation. However, an emergency room physician who is not authorized
 30 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
 31 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
 32 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
 33 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

34 (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an at-
 35 tending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician
 36 at the time of claim closure may make findings regarding the worker's impairment for the purpose
 37 of evaluating the worker's disability.

38 [(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed
 39 under ORS 678.375 to 678.390 or a physician associate licensed by the Oregon Medical Board in ac-
 40 cordance with ORS 677.505 to 677.525 or a similarly licensed physician associate in any country or in
 41 any state, territory or possession of the United States:]

42 [(i) May provide compensable medical services for 180 days from the date of the first visit on the
 43 initial claim;]

44 [(ii) May authorize the payment of temporary disability benefits for a period not to exceed 180 days
 45 from the date of the first visit on the initial claim; and]

1 *[(iii) When an injured worker treating with a nurse practitioner or physician associate authorized*
 2 *to provide compensable services under this section becomes medically stationary within the 180-day*
 3 *period in which the nurse practitioner or physician associate is authorized to treat the injured worker,*
 4 *shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS*
 5 *656.005 for the purpose of making findings regarding the worker's impairment for the purpose of*
 6 *evaluating the worker's disability. If a worker returns to the nurse practitioner or physician associate*
 7 *after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse*
 8 *practitioner or physician associate shall refer the worker to an attending physician and the insurer*
 9 *shall compensate the nurse practitioner or physician associate for the examination performed.]*

10 (3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice
 11 of the committee created by ORS 656.794 and upon the advice of the professional licensing boards
 12 of practitioners affected by the rule, may exclude from compensability any medical treatment the
 13 director finds to be unscientific, unproven, outmoded or experimental. The decision of the director
 14 is subject to review under ORS 656.704.

15 (4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer
 16 of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for
 17 medical services required by this chapter to be provided to injured workers:

18 (a) Those workers who are subject to the contract shall receive medical services in the manner
 19 prescribed in the contract. Workers subject to the contract include those who are receiving medical
 20 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
 21 jury or medically stationary status, on or after the effective date of the contract. If the managed
 22 care organization determines that the change in provider would be medically detrimental to the
 23 worker, the worker shall not become subject to the contract until the worker is found to be med-
 24 ically stationary, the worker changes physicians [*or nurse practitioners*], or the managed care or-
 25 ganization determines that the change in provider is no longer medically detrimental, whichever
 26 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
 27 notice of the worker's enrollment in the managed care organization, or upon the third day after the
 28 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
 29 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
 30 worker may continue to treat with the attending physician [*or nurse practitioner*] authorized to
 31 provide compensable medical services under this section under an expired or terminated managed
 32 care organization contract if the **attending** physician [*or nurse practitioner*] agrees to comply with
 33 the rules, terms and conditions regarding services performed under any subsequent managed care
 34 organization contract to which the worker is subject. A worker shall not be subject to a contract
 35 if the worker's primary residence is more than 100 miles outside the managed care organization's
 36 certified geographical area. Each such contract must comply with the certification standards pro-
 37 vided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that
 38 is compensable from a medical service provider who is not a member of the managed care organ-
 39 ization. Insurers or self-insured employers who contract with a managed care organization for med-
 40 ical services shall give notice to the workers of eligible medical service providers and such other
 41 information regarding the contract and manner of receiving medical services as the director may
 42 prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying
 43 employer is considered to be subject to a contract between the State Accident Insurance Fund
 44 Corporation as a processing agent or the assigned claims agent and a managed care organization.

45 (b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-

1 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
2 vices from the managed care organization.

3 (B) If the insurer or self-insured employer gives notice that the worker is required to receive
4 treatment from the managed care organization, the insurer or self-insured employer must guarantee
5 that any reasonable and necessary services so received, that are not otherwise covered by health
6 insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker
7 receives actual notice of the denial or until three days after the denial is mailed, whichever event
8 first occurs. The worker may elect to receive care from a primary care physician, nurse practitioner
9 or physician associate authorized to provide compensable medical services under this section who
10 agrees to the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the
11 insurer or self-insured employer if this election is made.

12 (C) If the insurer or self-insured employer does not give notice that the worker is required to
13 receive treatment from the managed care organization, the insurer or self-insured employer is under
14 no obligation to pay for services received by the worker unless the claim is later accepted.

15 (D) If the claim is denied, the worker may receive medical services after the date of denial from
16 sources other than the managed care organization until the denial is reversed. Reasonable and
17 necessary medical services received from sources other than the managed care organization after
18 the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured em-
19 ployer if the claim is finally determined to be compensable.

20 (5)(a) A nurse practitioner[,] or a physician associate described in ORS 656.005 [(12)(b)(C),]
21 **(12)(b)(A)(iv) or (v)** who is not a member of the managed care organization is authorized to provide
22 the same level of services as a primary care physician as established by ORS 656.260 (4) if the nurse
23 practitioner or physician associate:

24 (A) Maintains the worker's medical records;

25 (B) Has a documented history of treatment with the worker;

26 (C) Agrees to refer the worker to the managed care organization for any specialized treatment,
27 including physical therapy, to be furnished by another provider that the worker may require; and

28 (D) Agrees to comply with all the rules, terms and conditions regarding services performed by
29 the managed care organization.

30 (b)[(A)] A nurse practitioner or physician associate authorized to provide medical services to a
31 worker enrolled in the managed care organization may:

32 [(i)] **(A)** Provide medical treatment to the worker if the treatment is determined to be medically
33 appropriate according to the service utilization review process of the managed care organization;
34 and

35 [(ii)] **(B)** Authorize temporary disability payments [*as provided in subsection (2)(b)(D) of this*
36 *section*].

37 [(B) *The managed care organization may also authorize the nurse practitioner or physician asso-*
38 *ciate to provide medical services and authorize temporary disability payments beyond the periods es-*
39 *tablished in subsection (2)(b)(D) of this section.*]

40 (6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the
41 injured worker, insurer or self-insured employer may request administrative review by the director
42 pursuant to ORS 656.260 or 656.327.

43 **SECTION 47.** ORS 656.250 is amended to read:

44 656.250. A physical therapist [*shall*] **may** not provide compensable services to injured workers
45 governed by this chapter except as allowed by a governing managed care organization contract or

1 as authorized by the worker's attending physician [*or nurse practitioner authorized to provide*
2 *compensable medical services under ORS 656.245*].

3 **SECTION 48.** ORS 656.252 is amended to read:

4 656.252. (1) In order to ensure the prompt and correct reporting and payment of compensation
5 in compensable injuries, the Director of the Department of Consumer and Business Services shall
6 make rules governing audits of medical service bills and reports by attending and consulting physi-
7 cians and other personnel of all medical information relevant to the determination of a claim to the
8 injured worker's representative, the worker's employer, the employer's insurer and the Department
9 of Consumer and Business Services. Such rules shall include, but not necessarily be limited to:

10 (a) Requiring attending physicians [*and nurse practitioners authorized to provide compensable*
11 *medical services under ORS 656.245*] to make the insurer or self-insured employer a first report of
12 injury within 72 hours after the first service rendered.

13 (b) Requiring attending physicians [*and nurse practitioners authorized to provide compensable*
14 *medical services under ORS 656.245*] to submit follow-up reports within specified time limits or upon
15 the request of an interested party.

16 (c) Requiring examining physicians [*and nurse practitioners authorized to provide compensable*
17 *medical services under ORS 656.245*] to submit their reports, and to whom, within a specified time.

18 (d) Such other reporting requirements as the director may deem necessary to insure that pay-
19 ments of compensation be prompt and that all interested parties be given information necessary to
20 the prompt determination of claims.

21 (e) Requiring insurers and self-insured employers to audit billings for all medical services, in-
22 cluding hospital services.

23 (2) The attending physician [*or nurse practitioner authorized to provide compensable medical ser-*
24 *vices under ORS 656.245*] shall do the following:

25 (a) Cooperate with the insurer or self-insured employer to expedite diagnostic and treatment
26 procedures and with efforts to return injured workers to appropriate work.

27 (b) Advise the insurer or self-insured employer of the anticipated date for release of the injured
28 worker to return to employment, the anticipated date that the worker will be medically stationary,
29 and the next appointment date. Except when the attending physician [*or nurse practitioner author-*
30 *ized to provide compensable medical services under ORS 656.245*] has previously indicated that tem-
31 porary disability will not exceed 14 days, the insurer or self-insured employer may request a medical
32 report every 15 days, and the attending physician [*or nurse practitioner*] shall forward such reports.

33 (c) Advise the insurer or self-insured employer within five days of the date the injured worker
34 is released to return to work. Under no circumstances shall the physician [*or nurse practitioner*
35 *authorized to provide compensable medical services under ORS 656.245*] notify the insurer or employer
36 of the worker's release to return to work without notifying the worker at the same time.

37 (d) After a claim has been closed, advise the insurer or self-insured employer within five days
38 after the treatment is resumed or the reopening of a claim is recommended. The attending physician
39 under this paragraph need not be the same attending physician who released the worker when the
40 claim was closed.

41 (3) In promulgating the rules regarding medical reporting the director may consult and confer
42 with physicians and members of medical associations and societies.

43 (4) No person who reports medical information to a person referred to in subsection (1) of this
44 section, in accordance with department rules, shall incur any legal liability for the disclosure of
45 such information.

1 (5) Whenever an injured worker changes attending [*physicians or nurse practitioners authorized*
 2 *to provide compensable medical services under ORS 656.245*] **physician**, the newly selected attending
 3 physician [*or nurse practitioner*] shall so notify the responsible insurer or self-insured employer not
 4 later than five days after the date of the change or the date of first treatment. Every attending
 5 physician [*or nurse practitioner authorized to provide compensable medical services under ORS*
 6 *656.245*] who refers a worker to a consulting physician promptly shall notify the responsible insurer
 7 or self-insured employer of the referral.

8 (6) A provider of medical services, including hospital services, that submits a billing to the
 9 insurer or self-insured employer shall also submit a copy of the billing to the worker for whom the
 10 service was performed after receipt from the injured worker of a written request for such a copy.

11 **SECTION 49.** ORS 656.262 is amended to read:

12 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 13 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 14 claims as required in this chapter.

15 (2) The compensation due under this chapter shall be paid periodically, promptly and directly
 16 to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except
 17 where the right to compensation is denied by the insurer or self-insured employer.

18 (3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any
 19 claims or accidents which may result in a compensable injury claim, report the same to their
 20 insurer. The report shall include:

21 (A) The date, time, cause and nature of the accident and injuries.

22 (B) Whether the accident arose out of and in the course of employment.

23 (C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
 24 therefor.

25 (D) The name and address of any health insurance provider for the injured worker.

26 (E) Any other details the insurer may require.

27 (b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
 28 for any penalty the insurer is required to pay under subsection (11) of this section because of such
 29 failure. As used in this subsection, "health insurance" has the meaning for that term provided in
 30 ORS 731.162.

31 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
 32 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-
 33 bility, if the attending physician [*or nurse practitioner authorized to provide compensable medical*
 34 *services under ORS 656.245*] authorizes the payment of temporary disability compensation. There-
 35 after, temporary disability compensation shall be paid at least once each two weeks, except where
 36 the Director of the Department of Consumer and Business Services determines that payment in in-
 37 stallments should be made at some other interval. The director may by rule convert monthly benefit
 38 schedules to weekly or other periodic schedules.

39 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an
 40 injured worker who becomes disabled the same wage at the same pay interval that the worker re-
 41 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability
 42 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

43 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
 44 injured in the course and scope of that public office, full official salary paid to the holder of that
 45 public office shall be deemed timely payment of temporary disability payments pursuant to ORS

1 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, “public
2 office” has the meaning for that term provided in ORS 260.005.

3 (d) Temporary disability compensation is not due and payable for any period of time for which
4 the insurer or self-insured employer has requested from the worker’s attending physician [*or nurse
5 practitioner authorized to provide compensable medical services under ORS 656.245*] verification of the
6 worker’s inability to work resulting from the claimed injury or disease and the **attending** physician
7 [*or nurse practitioner*] cannot verify the worker’s inability to work, unless the worker has been un-
8 able to receive treatment for reasons beyond the worker’s control.

9 (e) If a worker fails to appear at an appointment with the worker’s attending physician [*or nurse
10 practitioner authorized to provide compensable medical services under ORS 656.245*], the insurer or
11 self-insured employer shall notify the worker by certified mail that temporary disability benefits may
12 be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to
13 appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of
14 temporary disability benefits to the worker until the worker appears at a subsequent rescheduled
15 appointment.

16 (f) If the insurer or self-insured employer has requested and failed to receive from the worker’s
17 attending physician [*or nurse practitioner authorized to provide compensable medical services under
18 ORS 656.245*] verification of the worker’s inability to work resulting from the claimed injury or
19 disease, medical services provided by the attending physician [*or nurse practitioner*] are not
20 compensable until the attending physician [*or nurse practitioner*] submits such verification.

21 (g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after
22 the worker’s attending physician [*or nurse practitioner authorized to provide compensable medical
23 services under ORS 656.245*] ceases to authorize temporary disability or for any period of time not
24 authorized by the attending physician [*or nurse practitioner*]. No authorization of temporary disabil-
25 ity compensation by the attending physician [*or nurse practitioner*] under ORS 656.268 shall be ef-
26 fective to retroactively authorize the payment of temporary disability more than 45 days prior to its
27 issuance.

28 (B) Subparagraph (A) of this paragraph does not apply:

29 (i) During periods in which there is a denial under the jurisdiction of the Workers’ Compens-
30 ation Board that affects the worker’s ability to obtain authorization of temporary disability;

31 (ii) During periods in which there is a dispute over the identity of, or treatment by, an attending
32 physician [*or nurse practitioner*] that affects the worker’s ability to obtain authorization of temporary
33 disability; or

34 (iii) When notice has not been given pursuant to paragraph (j) of this subsection.

35 (h) The worker’s disability may be authorized only by [*a person described*] **an attending physi-
36 cian as defined** in ORS 656.005 (12)(b)(B), or **a person described in ORS 656.245**, for the period
37 of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend
38 payment of temporary disability benefits to the worker at the expiration of the period until tempo-
39 rary disability is reauthorized by [*an*] **the** attending physician [*or nurse practitioner authorized to
40 provide compensable medical services under ORS 656.245*].

41 (i) The insurer or self-insured employer may unilaterally suspend payment of all compensation
42 to a worker enrolled in a managed care organization if the worker continues to seek care from an
43 attending physician [*or nurse practitioner authorized to provide compensable medical services under
44 ORS 656.245*] that is not authorized by the managed care organization more than seven days after
45 the mailing of notice by the insurer or self-insured employer.

1 (j)(A) The insurer or self-insured employer may not end temporary disability benefits until writ-
2 ten notice has been mailed or delivered to the worker and the worker's attorney, if the worker is
3 represented. The notice must state the reason that temporary disability benefits are no longer due
4 and payable.

5 (B) The worker's attending physician [*or nurse practitioner*] may retroactively authorize tempo-
6 rary disability for up to 45 days prior to the date of the notice.

7 (C) If the notice required under subparagraph (A) of this paragraph is given more than 45 days
8 after the worker was no longer eligible for benefits, the attending physician [*or nurse practitioner*]
9 may retroactively authorize temporary disability back to the date on which benefits were no longer
10 due and payable, provided the authorization is made within 30 days following the earlier of the date
11 of mailing or delivery of the written notice that the eligibility ended to the worker and the worker's
12 attorney, if the worker is represented.

13 (5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per
14 claim not to exceed the maximum amount established annually by the Director of the Department
15 of Consumer and Business Services, for medical services for nondisabling claims, may be made by
16 the subject employer if the employer so chooses. The making of such payments does not constitute
17 a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer
18 chooses to make such payment, the employer shall report the injury to the insurer in the same
19 manner that other injuries are reported. However, an insurer shall not modify an employer's expe-
20 rience rating or otherwise make charges against the employer for any medical expenses paid by the
21 employer pursuant to this subsection.

22 (b) To establish the maximum amount an employer may pay for medical services for nondisabling
23 claims under paragraph (a) of this subsection, the director shall use \$1,500 as the base compensation
24 amount and shall adjust the base compensation amount annually to reflect changes in the United
25 States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of
26 each year as published by the Bureau of Labor Statistics of the United States Department of Labor.
27 The adjustment shall be rounded to the nearest multiple of \$100.

28 (c) The adjusted amount established under paragraph (b) of this subsection shall be effective on
29 January 1 following the establishment of the amount and shall apply to claims with a date of injury
30 on or after the effective date of the adjusted amount.

31 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
32 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
33 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
34 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
35 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
36 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
37 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
38 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
39 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
40 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
41 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
42 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
43 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
44 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
45 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the

1 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
2 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
3 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
4 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
5 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
6 payable from the date any such benefits were terminated under the denial. Except as provided in
7 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
8 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
9 a copy of the notice of acceptance.

10 (b) The notice of acceptance shall:

11 (A) Specify what conditions are compensable.

12 (B) Advise the claimant whether the claim is considered disabling or nondisabling.

13 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
14 rights concerning nondisabling injuries, including the right to object to a decision that the injury
15 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

16 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
17 chapter 659A.

18 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
19 ment Assistance Program under ORS 656.622.

20 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
21 information changes a previously issued notice of acceptance.

22 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
23 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
24 the insurer or self-insured employer from later denying the combined or consequential condition if
25 the otherwise compensable injury ceases to be the major contributing cause of the combined or
26 consequential condition.

27 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
28 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
29 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
30 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
31 revise the notice or to make other written clarification in response. A worker who fails to comply
32 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
33 hearing or other proceeding on the claim a de facto denial of a condition based on information in
34 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
35 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

36 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
37 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be
38 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
39 or self-insured employer receives written notice of such claims. A worker who fails to comply with
40 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
41 any hearing or other proceeding on the claim a de facto denial of a condition based on information
42 in the notice of acceptance from the insurer or self-insured employer.

43 (b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a
44 written denial to the worker when the accepted injury is no longer the major contributing cause
45 of the worker's combined condition before the claim may be closed.

1 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
2 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
3 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
4 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
5 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
6 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
7 garding that condition.

8 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
9 ceptance or denial to the noncomplying employer.

10 (9) If an insurer or any other duly authorized agent of the employer for such purpose, on record
11 with the Director of the Department of Consumer and Business Services denies a claim for com-
12 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
13 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the
14 claimant. The insurer shall issue a copy of the notice of denial to the employer. The insurer shall
15 notify the director of the denial in the manner the director prescribes by rule. The worker may re-
16 quest a hearing pursuant to ORS 656.319.

17 (10) Merely paying or providing compensation shall not be considered acceptance of a claim or
18 an admission of liability, nor shall mere acceptance of such compensation be considered a waiver
19 of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a
20 notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review
21 of such an order or notice of closure, shall not preclude an insurer or self-insured employer from
22 subsequently contesting the compensability of the condition rated therein, unless the condition has
23 been formally accepted.

24 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
25 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
26 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the
27 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
28 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable
29 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court
30 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-
31 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and
32 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed
33 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under
34 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the
35 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this
36 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-
37 ment and payment of the additional amount and attorney fees described in this subsection. The
38 action of the director and the review of the action taken by the director shall be subject to review
39 under ORS 656.704.

40 (b) When the director does not have exclusive jurisdiction over proceedings regarding the as-
41 sessment and payment of the additional amount and attorney fees described in this subsection, the
42 provisions of this subsection shall apply in the other proceeding.

43 (12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the
44 insurer or self-insured employer has failed to make the payment in accordance with the requirements
45 specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly no-

1 tify the insurer or self-insured employer in writing that the payment is past due. If the required
2 payment is not made within five business days after receipt of the notice by the insurer or self-
3 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
4 adopted by the director by rule.

5 (b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney
6 fees authorized under this subsection. The matrix shall provide for penalties based on a percentage
7 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of
8 the settlement proceeds allocated to the claimant's attorney as an attorney fee.

9 (13) The insurer may authorize an employer to pay compensation to injured workers and shall
10 reimburse employers for compensation so paid.

11 (14)(a) Injured workers have the duty to cooperate and assist the insurer or self-insured em-
12 ployer in the investigation of claims for compensation. Injured workers shall submit to and shall
13 fully cooperate with personal and telephonic interviews and other formal or informal information
14 gathering techniques. Injured workers who are represented by an attorney shall have the right to
15 have the attorney present during any personal or telephonic interview or deposition. If the injured
16 worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a
17 reasonable attorney fee based upon an hourly rate for actual time spent during the personal or
18 telephonic interview or deposition. After consultation with the Board of Governors of the Oregon
19 State Bar, the Workers' Compensation Board shall adopt rules for the establishment, assessment and
20 enforcement of an hourly attorney fee rate specified in this subsection.

21 (b) If the attorney is not willing or available to participate in an interview at a time reasonably
22 chosen by the insurer or self-insured employer within 14 days of the request for interview and the
23 insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavail-
24 ability is unreasonable and is preventing the worker from complying within 14 days of the request
25 for interview, the insurer or self-insured employer shall notify the director. If the director deter-
26 mines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess
27 a civil penalty against the attorney of not more than \$1,000.

28 (15) If the director finds that a worker fails to reasonably cooperate with an investigation in-
29 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the
30 claim for a worsened condition, the director shall suspend all or part of the payment of compen-
31 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after
32 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure
33 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim
34 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the
35 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the
36 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291
37 that the worker fully and completely cooperated with the investigation, that the worker failed to
38 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-
39 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-
40 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain
41 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-
42 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order
43 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or
44 self-insured employer to accept or deny the claim.

45 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for

1 hearing for a claim for compensation involving more than one potentially responsible employer or
2 insurer may specify what is required of an injured worker to reasonably cooperate with the inves-
3 tigation of the claim as required by subsection (14) of this section.

4 **SECTION 50.** ORS 656.268 is amended to read:

5 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
6 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
7 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
8 Department of Consumer and Business Services, and determine the extent of the worker's permanent
9 disability, provided the worker is not enrolled and actively engaged in training according to rules
10 adopted by the director pursuant to ORS 656.340 and 656.726, when one of the following conditions
11 is met:

12 (a) The worker has become medically stationary and there is sufficient information to determine
13 permanent disability. Notwithstanding any other provision of this chapter, a physician [*or nurse*
14 *practitioner*] may not retroactively determine a worker to be medically stationary more than 60 days
15 prior to the date of the determination except in the case of claims that are subject to subsection (13)
16 of this section. An insurer or self-insured employer must mail or deliver written notice to a worker
17 and to the worker's attorney, if the worker is represented, within seven days following receipt of
18 information that the worker is medically stationary.

19 (b) The accepted injury is no longer the major contributing cause of the worker's combined or
20 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
21 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
22 quential condition or conditions, and there is sufficient information to determine permanent disabil-
23 ity, the likely permanent disability that would have been due to the current accepted condition shall
24 be estimated.

25 (c) Without the approval of the attending physician [*or nurse practitioner authorized to provide*
26 *compensable medical services under ORS 656.245*], the worker fails to seek medical treatment for a
27 period of 30 days or the worker fails to attend a closing examination, unless the worker
28 affirmatively establishes that such failure is attributable to reasons beyond the worker's control.

29 (d) An insurer or self-insured employer finds that a worker who has been receiving permanent
30 total disability benefits has materially improved and is capable of regularly performing work at a
31 gainful and suitable occupation.

32 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
33 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
34 duced by any sums earned during the training.

35 (3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors
36 shall be furnished to the worker, if requested by the worker.

37 (4) Temporary total disability benefits shall continue until whichever of the following events
38 first occurs:

39 (a) The worker returns to regular or modified employment;

40 (b) The attending physician [*or nurse practitioner who has authorized temporary disability benefits*
41 *for the worker under ORS 656.245*] advises the worker and documents in writing that the worker is
42 released to return to regular employment;

43 (c) The attending physician [*or nurse practitioner who has authorized temporary disability benefits*
44 *for the worker under ORS 656.245*] advises the worker and documents in writing that the worker is
45 released to return to modified employment, such employment is offered in writing to the worker and

1 the worker fails to begin such employment. However, an offer of modified employment may be re-
2 fused by the worker without the termination of temporary total disability benefits if the offer:

3 (A) Requires a commute that is beyond the physical capacity of the worker according to the
4 worker's attending physician [*or the nurse practitioner who may authorize temporary disability under*
5 *ORS 656.245*];

6 (B) Is at a work site more than 50 miles one way from where the worker was injured unless the
7 site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire
8 or as established by the pattern of employment prior to the injury was that the employer had mul-
9 tiple or mobile work sites and the worker could be assigned to any such site;

10 (C) Is not with the employer at injury;

11 (D) Is not at a work site of the employer at injury;

12 (E) Is not consistent with the existing written shift change policy or is not consistent with
13 common practice of the employer at injury or aggravation; or

14 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
15 gaining agreement;

16 (d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
17 or terminated under ORS 656.262 (4) or other provisions of this chapter; or

18 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician
19 [*or nurse practitioner who has authorized temporary disability benefits under ORS 656.245*] for a home
20 care worker or a personal support worker who has been made a subject worker pursuant to ORS
21 656.039 advises the home care worker or personal support worker and documents in writing that the
22 home care worker or personal support worker is released to return to modified employment, appro-
23 priate modified employment is offered in writing by the Home Care Commission or a designee of the
24 commission to the home care worker or personal support worker for any client of the Department
25 of Human Services who employs a home care worker or personal support worker and the worker
26 fails to begin the employment.

27 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
28 ability in closure of the claim shall be pursuant to the standards prescribed by the director.

29 (b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker
30 and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall
31 notify the director of the closure in the manner the director prescribes by rule. If the worker is
32 deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail
33 the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last
34 known address and may mail copies of the notice of closure to any known or potential beneficiaries
35 to the estate of the deceased worker.

36 (c) The notice of closure must inform:

37 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
38 isfied with the terms of the notice of closure;

39 (B) The worker of:

40 (i) The amount of any further compensation, including permanent disability compensation to be
41 awarded;

42 (ii) The duration of temporary total or temporary partial disability compensation;

43 (iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice
44 of closure under paragraph (b) of this subsection to request reconsideration by the director under
45 this section within 60 days of the date of the notice of closure;

1 (iv) The right of beneficiaries who were not mailed a copy of the notice of closure under para-
2 graph (b) of this subsection to request reconsideration by the director under this section within one
3 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
4 of this subsection;

5 (v) The right of the insurer or self-insured employer to request reconsideration by the director
6 under this section within seven days of the date of the notice of closure;

7 (vi) The aggravation rights; and

8 (vii) Any other information as the director may require; and

9 (C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204
10 and 656.208.

11 (d) If the insurer or self-insured employer has not issued a notice of closure, the worker may
12 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
13 self-insured employer shall issue a notice of closure if the requirements of this section have been
14 met or a notice of refusal to close if the requirements of this section have not been met. A notice
15 of refusal to close shall advise the worker of:

16 (A) The decision not to close;

17 (B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the
18 date of the notice of refusal to close;

19 (C) The right to be represented by an attorney; and

20 (D) Any other information as the director may require.

21 (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the no-
22 tice of closure, the objecting party first must request reconsideration by the director under this
23 section. A worker's request for reconsideration must be made within 60 days of the date of the no-
24 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for
25 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under
26 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.
27 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not
28 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within
29 one year of the date the notice of closure was mailed to the estate of the worker under paragraph
30 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be
31 based only on disagreement with the findings used to rate impairment and must be made within
32 seven days of the date of the notice of closure.

33 (f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant
34 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing
35 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close
36 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid
37 to the worker in an amount equal to 25 percent of all compensation determined to be then due the
38 claimant.

39 (g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
40 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
41 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
42 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
43 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
44 the claimant. If the increase in compensation results from information that the insurer or self-
45 insured employer demonstrates the insurer or self-insured employer could not reasonably have

1 known at the time of claim closure, from new information obtained through a medical arbiter ex-
2 amination or from a determination order issued by the director that addresses the extent of the
3 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
4 (4)(f), the penalty shall not be assessed.

5 (6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
6 held on each notice of closure. At the reconsideration proceeding:

7 (A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
8 worker about the worker's condition at the time of claim closure, shall become part of the recon-
9 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
10 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
11 cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the
12 deposition for the Department of Consumer and Business Services and one copy of the transcript
13 of the deposition for each party shall be paid by the insurer or self-insured employer. The recon-
14 sideration proceeding may not be postponed to receive a deposition taken under this subparagraph.
15 A deposition taken in accordance with this subparagraph may be received as evidence at a hearing
16 even if the deposition is not prepared in time for use in the reconsideration proceeding.

17 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
18 may correct information in the record that is erroneous and may submit any medical evidence that
19 should have been but was not submitted by the attending physician [*or nurse practitioner authorized*
20 *to provide compensable medical services under ORS 656.245*] at the time of claim closure.

21 (C) If the director determines that a claim was not closed in accordance with subsection (1) of
22 this section, the director may rescind the closure.

23 (b) If necessary, the director may require additional medical or other information with respect
24 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

25 (c) In any reconsideration proceeding under this section in which the worker was represented
26 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
27 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
28 pensation awarded to the worker.

29 (d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be
30 completed within 18 working days from the date the reconsideration proceeding begins, and shall
31 be performed by a special evaluation appellate unit within the department. The deadline of 18
32 working days may be postponed by an additional 60 calendar days if within the 18 working days the
33 department mails notice of review by a medical arbiter. If an order on reconsideration has not been
34 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within
35 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was
36 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-
37 section, or within such additional time as provided in subsection (8) of this section when reconsid-
38 eration is postponed further because the worker has failed to cooperate in the medical arbiter
39 examination, reconsideration shall be deemed denied and any further proceedings shall occur as
40 though an order on reconsideration affirming the notice of closure was mailed on the date the order
41 was due to issue.

42 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
43 subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-
44 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
45 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the

1 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
2 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
3 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
4 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
5 ation proceeding, including the right to proceed with the reconsideration if the initiating party
6 withdraws the request for reconsideration.

7 (f) Any medical arbiter report may be received as evidence at a hearing even if the report is
8 not prepared in time for use in the reconsideration proceeding.

9 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
10 656.283 within 30 days from the date of the reconsideration order.

11 (7)(a) The director may delay the reconsideration proceeding and toll the reconsideration
12 timeline established under subsection (6) of this section for up to 45 calendar days if:

13 (A) A request for reconsideration of a notice of closure has been made to the director within
14 60 days of the date of the notice of closure;

15 (B) The parties are actively engaged in settlement negotiations that include issues in dispute
16 at reconsideration;

17 (C) The parties agree to the delay; and

18 (D) Both parties notify the director before the 18th working day after the reconsideration pro-
19 ceeding has begun that they request a delay under this subsection.

20 (b) A delay of the reconsideration proceeding granted by the director under this subsection ex-
21 pires:

22 (A) If a party requests the director to resume the reconsideration proceeding before the expi-
23 ration of the delay period;

24 (B) If the parties reach a settlement and the director receives a copy of the approved settlement
25 documents before the expiration of the delay period; or

26 (C) On the next calendar day following the expiration of the delay period authorized by the di-
27 rector.

28 (c) Upon expiration of a delay granted under this subsection, the timeline for the completion of
29 the reconsideration proceeding shall resume as if the delay had never been granted.

30 (d) Compensation due the worker shall continue to be paid during the period of delay authorized
31 under this subsection.

32 (e) The director may authorize only one delay period for each reconsideration proceeding.

33 (8)(a) If the basis for objection to a notice of closure issued under this section is disagreement
34 with the impairment used in rating of the worker's disability, the director shall refer the claim to
35 a medical arbiter appointed by the director.

36 (b) If the director determines that insufficient medical information is available to determine
37 disability, the director may appoint, and refer the claim to, a medical arbiter.

38 (c) At the request of either of the parties, the director shall appoint a panel of as many as three
39 medical arbiters in accordance with criteria that the director sets by rule.

40 (d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians
41 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected
42 in consultation with the Oregon Medical Board, **the Oregon State Board of Nursing** and the
43 committee referred to in ORS 656.790.

44 (e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform
45 such tests as may be reasonable and necessary to establish the worker's impairment.

1 (B) If the director determines that the worker failed to attend the examination without good
2 cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall
3 postpone the reconsideration proceedings for up to 60 days from the date of the determination that
4 the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this
5 or any prior opening of the claim until such time as the worker attends and cooperates with the
6 examination or the request for reconsideration is withdrawn. Any additional evidence regarding
7 good cause must be submitted prior to the conclusion of the 60-day postponement period.

8 (C) At the conclusion of the 60-day postponement period, if the worker has not attended and
9 cooperated with a medical arbiter examination or established good cause, the worker may not attend
10 a medical arbiter examination for this claim closure. The reconsideration record must be closed, and
11 the director shall issue an order on reconsideration based upon the existing record.

12 (D) All disability benefits suspended under this subsection, including all disability benefits
13 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Com-
14 pensation Board or upon court review, are not due and payable to the worker.

15 (f) The insurer or self-insured employer shall pay the costs of examination and review by the
16 medical arbiter or panel of medical arbiters.

17 (g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the
18 director for reconsideration of the notice of closure.

19 (h) After reconsideration, no subsequent medical evidence of the worker's impairment is admis-
20 sible before the director, the Workers' Compensation Board or the courts for purposes of making
21 findings of impairment on the claim closure.

22 (i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement
23 with the impairment used in rating the worker's disability, and the director determines that the
24 worker is not medically stationary at the time of the reconsideration or that the closure was not
25 made pursuant to this section, the director is not required to appoint a medical arbiter before
26 completing the reconsideration proceeding.

27 (B) If the worker's condition has substantially changed since the notice of closure, upon the
28 consent of all the parties to the claim, the director shall postpone the proceeding until the worker's
29 condition is appropriate for claim closure under subsection (1) of this section.

30 (9) No hearing shall be held on any issue that was not raised and preserved before the director
31 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
32 resolved at hearing.

33 (10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
34 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
35 any permanent disability payments due for work disability under the closure shall be suspended, and
36 the worker shall receive temporary disability compensation and any permanent disability payments
37 due for impairment while the worker is enrolled and actively engaged in the training. When the
38 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
39 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
40 if the worker's accepted injury is no longer the major contributing cause of the worker's combined
41 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
42 duration of temporary total or temporary partial disability compensation. Permanent disability
43 compensation shall be redetermined for work disability only. If the worker has returned to work or
44 the worker's attending physician has released the worker to return to regular or modified employ-
45 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may

1 be appealed only in the same manner as are other notices of closure under this section.

2 (11) If the attending physician [*or nurse practitioner authorized to provide compensable medical*
3 *services under ORS 656.245*] has approved the worker's return to work and there is a labor dispute
4 in progress at the place of employment, the worker may refuse to return to that employment without
5 loss of reemployment rights or any vocational assistance provided by this chapter.

6 (12) Any notice of closure made under this section may include necessary adjustments in com-
7 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
8 bility payments prematurely made, crediting temporary disability payments against current or future
9 permanent or temporary disability awards or payments and requiring the payment of temporary
10 disability payments which were payable but not paid.

11 (13) An insurer or self-insured employer may take a credit or offset of previously paid workers'
12 compensation benefits or payments against any further workers' compensation benefits or payments
13 due a worker from that insurer or self-insured employer when the worker admits to having obtained
14 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
15 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
16 fits or payments obtained through fraud by a worker may not be included in any data used for
17 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-
18 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the
19 director.

20 (14)(a) An insurer or self-insured employer may offset any compensation payable to the worker
21 to recover an overpayment from a claim with the same insurer or self-insured employer. When
22 overpayments are recovered from temporary disability or permanent total disability benefits, the
23 amount recovered from each payment shall not exceed 25 percent of the payment, without prior
24 authorization from the worker.

25 (b) An insurer or self-insured employer may suspend and offset any compensation payable to the
26 beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused
27 by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the
28 death of the worker.

29 (15) Conditions that are direct medical sequelae to the original accepted condition shall be in-
30 cluded in rating permanent disability of the claim unless they have been specifically denied.

31 (16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured em-
32 ployer may not recover an overpayment from a worker's permanent partial disability compensation
33 for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total
34 compensation awarded to the worker.

35 (b) An insurer or self-insured employer may not declare an overpayment of any compensation
36 that was paid more than two years prior to the date of the declaration.

37 **SECTION 51.** ORS 656.325 is amended to read:

38 656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if
39 requested by the Director of the Department of Consumer and Business Services, the insurer or
40 self-insured employer, to submit to a medical examination at a time reasonably convenient for the
41 worker as may be provided by the rules of the director. No more than three independent medical
42 examinations may be requested except after notification to and authorization by the director. If the
43 worker refuses to submit to any such examination, or obstructs the same, the rights of the worker
44 to compensation shall be suspended with the consent of the director until the examination has taken
45 place, and no compensation shall be payable during or for account of such period. The provisions

1 of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

2 (b) When a worker is requested by the director, the insurer or self-insured employer to attend
3 an independent medical examination, the examination must be conducted by a physician selected
4 from a list of qualified physicians established by the director under ORS 656.328.

5 (c) The director shall adopt rules applicable to independent medical examinations conducted
6 pursuant to paragraph (a) of this subsection that:

7 (A) Provide a worker the opportunity to request review by the director of the reasonableness
8 of the location selected for an independent medical examination. Upon receipt of the request for
9 review, the director shall conduct an expedited review of the location selected for the independent
10 medical examination and issue an order on the reasonableness of the location of the examination.
11 The director shall determine if there is substantial evidence for the objection to the location for the
12 independent medical examination based on a conclusion that the required travel is medically
13 contraindicated or other good cause establishing that the required travel is unreasonable. The de-
14 terminations of the director about the location of independent medical examinations are not subject
15 to review.

16 (B) Impose a monetary penalty against a worker who fails to attend an independent medical
17 examination without prior notification or without justification for not attending the examination. A
18 penalty imposed under this subparagraph may be imposed only on a worker who is not receiving
19 temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may
20 offset any future compensation payable to the worker to recover any penalty imposed under this
21 subparagraph from a claim with the same insurer or self-insured employer. When a penalty is re-
22 covered from temporary disability or permanent total disability benefits, the amount recovered from
23 each payment may not exceed 25 percent of the benefit payment without prior authorization from
24 the worker.

25 (C) Impose a sanction against a medical service provider that unreasonably fails to provide in
26 a timely manner diagnostic records required for an independent medical examination.

27 (d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for an
28 independent medical examination is unreasonable, the insurer or self-insured employer shall accept
29 or deny the claim within 90 days after the employer has notice or knowledge of the claim.

30 (e) If the worker has made a timely request for a hearing on a denial of compensability as re-
31 quired by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pur-
32 suant to paragraph (a) of this subsection and the worker's attending physician [*or nurse practitioner*
33 *authorized to provide compensable medical services under ORS 656.245*] does not concur with the re-
34 port or reports, the worker may request an examination to be conducted by a physician selected by
35 the director from the list described in ORS 656.328. The cost of the examination and the examination
36 report shall be paid by the insurer or self-insured employer.

37 (f) The insurer or self-insured employer shall pay the costs of the medical examination and re-
38 lated services which are reasonably necessary to allow the worker to submit to any examination
39 requested under this section. As used in this paragraph, "related services" includes, but is not lim-
40 ited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages
41 for the period during which the worker is absent if the worker does not receive benefits pursuant
42 to ORS 656.210 (4) during the period of absence. A claim for "related services" described in this
43 paragraph shall be made in the manner prescribed by the director.

44 (g) A worker who objects to the location of an independent medical examination must request
45 review by the director under paragraph (c)(A) of this subsection within six business days of the date

1 the notice of the independent medical examination was mailed.

2 (2) For any period of time during which any worker commits insanitary or injurious practices
3 which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical
4 or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a
5 program of physical rehabilitation, the right of the worker to compensation shall be suspended with
6 the consent of the director and no payment shall be made for such period. The period during which
7 such worker would otherwise be entitled to compensation may be reduced with the consent of the
8 director to such an extent as the disability has been increased by such refusal.

9 (3) A worker who has received an award for permanent total or permanent partial disability
10 should be encouraged to make a reasonable effort to reduce the disability; and the award shall be
11 subject to periodic examination and adjustment in conformity with ORS 656.268.

12 (4) When the employer of an injured worker, or the employer's insurer determines that the in-
13 jured worker has failed to follow medical advice from the attending physician [*or nurse practitioner*
14 *authorized to provide compensable medical services under ORS 656.245*] or has failed to participate
15 in or complete physical restoration or vocational rehabilitation programs prescribed for the worker
16 pursuant to this chapter, the employer or insurer may petition the director for reduction of any
17 benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director
18 finds that the worker has failed to accept treatment as provided in this subsection, the director may
19 reduce any benefits awarded the worker by such amount as the director considers appropriate.

20 (5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer shall
21 cease making payments pursuant to ORS 656.210 and shall commence making payment of such
22 amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning em-
23 ployment prior to claim determination and the worker's attending physician [*or nurse practitioner*
24 *authorized to provide compensable medical services under ORS 656.245*], after being notified by the
25 employer of the specific duties to be performed by the injured worker, agrees that the injured
26 worker is capable of performing the employment offered.

27 (b) If the worker has been terminated for violation of work rules or other disciplinary reasons,
28 the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence
29 payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner authorized to*
30 *provide compensable medical services under ORS 656.245*] approves employment in a modified job that
31 would have been offered to the worker if the worker had remained employed, provided that the
32 employer has a written policy of offering modified work to injured workers.

33 (c) If the worker is a person present in the United States in violation of federal immigration
34 laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and com-
35 mence payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner au-*
36 *thorized to provide compensable medical services under ORS 656.245*] approves employment in a
37 modified job whether or not such a job is available.

38 (6) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

39 **SECTION 52.** ORS 656.340 is amended to read:

40 656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be pro-
41 vided to an injured worker who is eligible for assistance in returning to work.

42 (b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for
43 a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for
44 vocational assistance within five days of:

45 (A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical

1 or investigation report, notification from the worker, or otherwise; or

2 (B) The time the worker is medically stationary, if the worker has not returned to or been re-
3 leased for the worker's regular employment or has not returned to other suitable employment with
4 the employer at the time of injury or aggravation and the worker is not receiving vocational as-
5 sistance.

6 (c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new
7 information that would change the eligibility determination.

8 (2) Contact under subsection (1) of this section shall include informing the worker about reem-
9 ployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job
10 site modification assistance and the provisions of the preferred worker program pursuant to rules
11 adopted by the Director of the Department of Consumer and Business Services.

12 (3) Within five days after notification that the attending physician [*or nurse practitioner author-*
13 *ized to provide compensable medical services under ORS 656.245*] has released a worker to return to
14 work, the insurer or self-insured employer shall inform the worker about the opportunity to seek
15 reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the
16 employer of the worker's reemployment rights, wage subsidy and the job site modification assistance
17 and the provisions of the preferred worker program.

18 (4) As soon as possible, and not more than 30 days after the contact required by subsection (1)
19 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-
20 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-
21 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the
22 worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the
23 worker is not eligible, the worker may apply to the director for review of the decision as provided
24 in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection
25 (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under stan-
26 dards prescribed by the director, may not be found eligible thereafter unless that eligibility deter-
27 mination is rejected by the director under subsection (16) of this section or the worker's condition
28 worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to
29 vocational assistance benefits when possible eligibility for such benefits arises from a worsening of
30 the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS
31 656.273.

32 (5) The objectives of vocational assistance are to return the worker to employment which is as
33 close as possible to the worker's regular employment at a wage as close as possible to the weekly
34 wage currently being paid for employment which was the worker's regular employment even though
35 the wage available following employment may be less than the wage prescribed by subsection (6)
36 of this section. As used in this subsection and subsection (6) of this section, "regular employment"
37 means the employment the worker held at the time of the injury or the claim for aggravation under
38 ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a
39 worker not employed at the time of the aggravation, the employment the worker held on the last
40 day of work prior to the aggravation.

41 (6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to
42 the previous employment or to any other available and suitable employment with the employer at
43 the time of injury or aggravation, and the worker has a substantial handicap to employment.

44 (b) As used in this subsection:

45 (A) A "substantial handicap to employment" exists when the worker, because of the injury or

1 aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed
2 in suitable employment.

3 (B) "Suitable employment" means:

4 (i) Employment of the kind for which the worker has the necessary physical capacity, knowl-
5 edge, skills and abilities;

6 (ii) Employment that is located where the worker customarily worked or is within reasonable
7 commuting distance of the worker's residence; and

8 (iii) Employment that produces a weekly wage within 20 percent of that currently being paid for
9 employment that was the worker's regular employment as defined in subsection (5) of this section.
10 The director shall adopt rules providing methods of calculating the weekly wage currently being
11 paid for the worker's regular employment for use in determining eligibility and for providing as-
12 sistance to eligible workers. If the worker's regular employment was seasonal or temporary, the
13 worker's wage shall be averaged based on a combination of the worker's earned income and any
14 unemployment insurance payments. Only earned income evidenced by verifiable documentation such
15 as federal or state tax returns shall be used in the calculation. Earned income does not include
16 fringe benefits or reimbursement of the worker's employment expenses.

17 (7) Vocational evaluation, help in directly obtaining employment and training shall be available
18 under conditions prescribed by the director. The director may establish other conditions for pro-
19 viding vocational assistance, including those relating to the worker's availability for assistance,
20 participation in previous assistance programs connected with the same claim and the nature and
21 extent of assistance that may be provided. Such conditions shall give preference to direct employ-
22 ment assistance over training.

23 (8) An insurer or self-insured employer may utilize its own staff or may engage any other indi-
24 vidual certified by the director to perform the vocational evaluation required by subsection (4) of
25 this section.

26 (9) The director shall adopt rules providing:

27 (a) Standards for and methods of certifying individuals qualified by education, training and ex-
28 perience to provide vocational assistance to injured workers;

29 (b) Standards for registration of vocational assistance providers;

30 (c) Conditions and procedures under which the certification of an individual to provide voca-
31 tional assistance services or the registration of a vocational assistance provider may be suspended
32 or revoked for failure to maintain compliance with the certification or registration standards;

33 (d) Standards for the nature and extent of services a worker may receive, for plans for return
34 to work and for determining when the worker has returned to work; and

35 (e) Procedures, schedules and conditions relating to the payment for services performed by a
36 vocational assistance provider, that are based on payment for specific services performed and not
37 fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for
38 direct worker purchases and for all vocational assistance providers and shall be the same within
39 suitable geographic areas.

40 (10) Insurers and self-insured employers shall maintain records and make reports to the director
41 of vocational assistance actions at times and in the manner as the director may prescribe. The re-
42 quirements prescribed shall be for the purpose of assisting the Department of Consumer and Busi-
43 ness Services in monitoring compliance with this section to insure that workers receive timely and
44 appropriate vocational assistance. The director shall minimize to the greatest extent possible the
45 number, extent and kinds of reports required. The director shall compile a list of organizations or

1 agencies registered to provide vocational assistance. A current list shall be distributed by the di-
2 rector to all insurers and self-insured employers. The insurer shall send the list to each worker with
3 the notice of eligibility.

4 (11) When a worker is eligible to receive vocational assistance, the worker and the insurer or
5 self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the
6 worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational
7 assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-
8 insured employer shall notify the director and the director shall select a provider. Any change in
9 the choice of vocational assistance provider is subject to the approval of the director.

10 (12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary
11 disability compensation for a maximum of 16 months. The insurer or self-insured employer may vol-
12 untarily extend the payment of temporary disability compensation to a maximum of 21 months. The
13 director may order the payment of temporary disability compensation for up to 21 months upon good
14 cause shown by the injured worker. The costs related to vocational assistance training programs
15 may be paid for periods longer than 21 months, but in no event may temporary disability benefits
16 be paid for a period longer than 21 months.

17 (13) As used in this section, "vocational assistance provider" means a public or private organ-
18 ization or agency that provides vocational assistance to injured workers.

19 (14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the
20 same type or extent of assistance.

21 (b) Training shall not be provided to an eligible worker solely because the worker cannot obtain
22 employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this sec-
23 tion unless such training will enable the worker to find employment which will produce a wage
24 significantly closer to that prescribed in subsection (6) of this section.

25 (c) Nothing in this section shall be interpreted to expand the availability of training under this
26 section.

27 (15) A physical capacities evaluation shall be performed in conjunction with vocational assist-
28 ance or determination of eligibility for such assistance at the request of the insurer or self-insured
29 employer or worker. The request shall be made to the attending physician [*or nurse practitioner*
30 *authorized to provide compensable medical services under ORS 656.245*]. [*The attending physician or*
31 *nurse practitioner,*] Within 20 days of the request, **the attending physician** shall perform a physical
32 capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured
33 employer and the worker in writing that the injured worker is incapable of participating in a phys-
34 ical capacities evaluation.

35 (16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires
36 a high degree of cooperation between all of the participants in the vocational assistance process.
37 Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and
38 extent of vocational assistance services should be resolved through nonadversarial procedures to the
39 greatest extent possible consistent with constitutional principles. The director shall adopt by rule
40 a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

41 (b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding
42 vocational assistance, the worker must apply to the director for administrative review of the matter.
43 Application for review must be made not later than the 60th day after the date the worker was
44 notified of the action. The director shall complete the review within a reasonable time.

45 (c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall

1 be reduced to writing, and the director and the parties shall review the agreement and either ap-
2 prove or disapprove it. The agreement is subject to reconsideration by the director under limitations
3 prescribed by the director, but is not subject to review by any other forum.

4 (d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall
5 resolve the matter in a written order based on a record sufficient to permit review. The order is
6 subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the
7 date the order was issued. At the hearing, the order of the director shall be modified only if it:

8 (A) Violates a statute or rule;

9 (B) Exceeds the statutory authority of the agency;

10 (C) Was made upon unlawful procedure; or

11 (D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

12 (e) For purposes of this subsection, the term "parties" does not include a noncomplying em-
13 ployer.

14 **SECTION 53.** ORS 656.726 is amended to read:

15 656.726. (1) The Workers' Compensation Board in its name and the Director of the Department
16 of Consumer and Business Services in the director's name as director may sue and be sued, and each
17 shall have a seal.

18 (2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges
19 in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction
20 under this chapter and providing such policy advice as the director may request, and providing such
21 other review functions as may be prescribed by law. To that end any of its members or assistants
22 authorized thereto by the members shall have power to:

23 (a) Hold sessions at any place within the state.

24 (b) Administer oaths.

25 (c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attend-
26 ance of witnesses and the production of papers, contracts, books, accounts, documents and testimony
27 before any hearing under ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this
28 chapter.

29 (d) Generally provide for the taking of testimony and for the recording of proceedings.

30 (3) The board chairperson is hereby charged with the administration of and responsibility for the
31 Hearings Division.

32 (4) The director hereby is charged with duties of administration, regulation and enforcement of
33 ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter. To that end the di-
34 rector may:

35 (a) Make and declare all rules and issue orders which are reasonably required in the perform-
36 ance of the director's duties. Unless otherwise specified by law, all reports, claims or other docu-
37 ments shall be deemed timely provided to the director or board if mailed by regular mail or
38 delivered within the time required by law. Notwithstanding any other provision of this chapter, the
39 director may adopt rules to allow for the electronic transmission and filing of reports, claims or
40 other documents required to be filed under this chapter and to require the electronic transmission
41 and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding
42 ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the
43 director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable
44 or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order,
45 subject to review under ORS 656.704. Such order shall not have precedential effect as to any other

1 situation.

2 (b) Hold sessions at any place within the state.

3 (c) Administer oaths.

4 (d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
5 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
6 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director
7 or the director's representatives. The director may require the attendance and testimony of em-
8 ployers, their officers and representatives in any inquiry under this chapter, and the production by
9 employers of books, records, papers and documents without the payment or tender of witness fees
10 on account of such attendance.

11 (e) Generally provide for the taking of testimony and for the recording of such proceedings.

12 (f) Provide standards for the evaluation of disabilities. The following provisions apply to the
13 standards:

14 (A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use
15 or function of a body part or system due to the compensable industrial injury or occupational dis-
16 ease. Permanent impairment is expressed as a percentage of the whole person. The impairment value
17 may not exceed 100 percent of the whole person.

18 (B) Impairment is established by a preponderance of medical evidence based upon objective
19 findings.

20 (C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment
21 as modified by the factors of age, education and adaptability to perform a given job.

22 (D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that
23 the worker's disability is not addressed by the standards adopted pursuant to this paragraph,
24 notwithstanding ORS 656.268, the director shall, in the order on reconsideration, determine the ex-
25 tent of permanent disability that addresses the worker's impairment.

26 (E) Notwithstanding any other provision of this section, only impairment benefits shall be
27 awarded under ORS 656.214 if the worker has been released to regular work by the attending phy-
28 sician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*]
29 or has returned to regular work at the job held at the time of injury.

30 (g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings
31 pursuant to ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter regarding
32 all matters other than those specifically allocated to the board or the Hearings Division.

33 (h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals
34 in which the director determines that the proceeding involves a matter that affects or could affect
35 the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001
36 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

37 (5)(a) The board may make and declare all rules which are reasonably required in the perform-
38 ance of its duties, including but not limited to rules of practice and procedure in connection with
39 hearing and review proceedings and exercising its authority under ORS 656.278. The board shall
40 adopt standards governing the format and timing of the evidence. The standards shall be uniformly
41 followed by all Administrative Law Judges and practitioners. The rules may provide for informal
42 prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies,
43 if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who
44 may appear with parties at prehearing conferences and hearings.

45 (b) Notwithstanding any other provision of this chapter, the board may adopt rules to allow for

1 the electronic transmission of filings, reports, notices and other documents required to be filed under
2 the board's authority.

3 (6) The director and the board chairperson may incur such expenses as they respectively de-
4 termine are reasonably necessary to perform their authorized functions.

5 (7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall
6 have the right, not subject to review, to contract for the exchange of, or payment for, such services
7 between them as will reduce the overall cost of administering this chapter.

8 (8) The director shall have lien and enforcement powers regarding assessments to be paid by
9 subject employers in the same manner and to the same extent as is provided for lien and enforce-
10 ment of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

11 (9) The director shall have the same powers regarding inspection of books, records and payrolls
12 of employers as are granted the corporation under ORS 656.758. The director may disclose infor-
13 mation obtained from such inspections to the Director of the Department of Revenue to the extent
14 the Director of the Department of Revenue requires such information to determine that a person
15 complies with the revenue and tax laws of this state and to the Director of the Employment De-
16 partment to the extent the Director of the Employment Department requires such information to
17 determine that a person complies with ORS chapter 657.

18 (10) The director shall collect hours-worked data information in addition to total payroll for
19 workers engaged in various jobs in the construction industry classifications described in the job
20 classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon
21 Special Rules Section published by the National Council on Compensation Insurance. The informa-
22 tion shall be collected in the form and format necessary for the National Council on Compensation
23 Insurance to analyze premium equity.

24 **SECTION 54.** ORS 656.797 is amended to read:

25 656.797. On or after October 1, 2004, **prior to providing compensable medical services or**
26 **authorizing temporary disability benefits**, a nurse practitioner licensed under ORS 678.375 to
27 678.390[*prior to providing compensable medical services or authorizing temporary disability benefits*
28 *under ORS 656.245,*] **or a similarly licensed nurse practitioner in any country or in any state,**
29 **territory or possession of the United States** must certify in a form acceptable to the Director
30 of the Department of Consumer and Business Services that the nurse practitioner has reviewed the
31 materials developed under ORS 656.795.

32 **SECTION 55.** ORS 659A.043 is amended to read:

33 659A.043. (1) A worker who has sustained a compensable injury shall be reinstated by the
34 worker's employer to the worker's former position of employment upon demand for such rein-
35 statement, if the position exists and is available and the worker is not disabled from performing the
36 duties of such position. A worker's former position is available even if that position has been filled
37 by a replacement while the injured worker was absent. If the former position is not available, the
38 worker shall be reinstated in any other existing position that is vacant and suitable. A certificate
39 by the attending physician, **as defined in ORS 656.005 (12)**, [*or a nurse practitioner authorized to*
40 *provide compensable medical services under ORS 656.245*] that the **attending** physician [*or nurse*
41 *practitioner*] approves the worker's return to the worker's regular employment or other suitable
42 employment shall be prima facie evidence that the worker is able to perform such duties.

43 (2) Such right of reemployment shall be subject to the provisions for seniority rights and other
44 employment restrictions contained in a valid collective bargaining agreement between the employer
45 and a representative of the employer's employees.

1 (3) Notwithstanding subsection (1) of this section:

2 (a) The right to reinstatement to the worker's former position under this section terminates
3 when whichever of the following events first occurs:

4 [(A) A medical determination by the attending physician or, after an appeal of such determination
5 to a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656, has been made that the
6 worker cannot return to the former position of employment.]

7 **(A) The worker cannot return to the former position of employment according to:**

8 **(i) The medical determination of the attending physician; or**

9 **(ii) Upon appeal of the attending physician's determination, the determination of a med-
10 ical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

11 (B) The worker is eligible and participates in vocational assistance under ORS 656.340.

12 (C) The worker accepts suitable employment with another employer after becoming medically
13 stationary.

14 (D) The worker refuses a bona fide offer from the employer of light duty or modified employment
15 that is suitable prior to becoming medically stationary.

16 (E) Seven days elapse from the date that the worker is notified by the insurer or self-insured
17 employer by certified mail that the worker's attending physician [or a nurse practitioner authorized
18 to provide compensable medical services under ORS 656.245] has released the worker for employment
19 unless the worker requests reinstatement within that time period.

20 (F) Three years elapse from the date of injury.

21 (b) The right to reinstatement under this section does not apply to:

22 (A) A worker hired on a temporary basis as a replacement for an injured worker.

23 (B) A seasonal worker employed to perform less than six months' work in a calendar year.

24 (C) A worker whose employment at the time of injury resulted from referral from a hiring hall
25 operating pursuant to a collective bargaining agreement.

26 (D) A worker whose employer employs 20 or fewer workers at the time of the worker's injury
27 and at the time of the worker's demand for reinstatement.

28 (4) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
29 section (3)(a)(D) of this section and who otherwise is entitled to family leave under ORS 659A.150
30 to 659A.186:

31 (a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
32 refusing the offer of employment; and

33 (b) Need not give additional written or oral notice to the employer that the employee is com-
34 mencing a period of family leave.

35 (5) Any violation of this section is an unlawful employment practice.

36 **SECTION 56.** ORS 659A.046 is amended to read:

37 659A.046. (1) A worker who has sustained a compensable injury and is disabled from performing
38 the duties of the worker's former regular employment shall, upon demand, be reemployed by the
39 worker's employer at employment which is available and suitable.

40 (2) A certificate of the worker's attending physician, **as defined in ORS 656.005 (12)**, [or a nurse
41 practitioner authorized to provide compensable medical services under ORS 656.245] that the worker
42 is able to perform described types of work shall be prima facie evidence of such ability.

43 (3) Notwithstanding subsection (1) of this section, the right to reemployment under this section
44 terminates when whichever of the following events first occurs:

45 [(a) The worker cannot return to reemployment at any position with the employer either by deter-

1 *mination of the attending physician or a nurse practitioner authorized to provide compensable medical*
2 *services under ORS 656.245 or upon appeal of that determination, by determination of a medical arbiter*
3 *or panel of medical arbiters pursuant to ORS chapter 656.]*

4 **(a) The worker cannot return to reemployment at any position with the employer ac-**
5 **cording to:**

6 **(A) The determination of the attending physician; or**

7 **(B) Upon appeal of the attending physician's determination, the determination of a med-**
8 **ical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

9 (b) The worker is eligible and participates in vocational assistance under ORS 656.340.

10 (c) The worker accepts suitable employment with another employer after becoming medically
11 stationary.

12 (d) The worker refuses a bona fide offer from the employer of light duty or modified employment
13 that is suitable prior to becoming medically stationary.

14 (e) Seven days elapse from the date that the worker is notified by the insurer or self-insured
15 employer by certified mail that the worker's attending physician [*or a nurse practitioner authorized*
16 *to provide compensable medical services under ORS 656.245*] has released the worker for reemploy-
17 ment unless the worker requests reemployment within that time period.

18 (f) Three years elapse from the date of injury.

19 (4) Such right of reemployment shall be subject to the provisions for seniority rights and other
20 employment restrictions contained in a valid collective bargaining agreement between the employer
21 and a representative of the employer's employees.

22 (5) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
23 section (3)(d) of this section and who otherwise is entitled to family leave under ORS 659A.150 to
24 659A.186:

25 (a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
26 refusing the offer of employment; and

27 (b) Need not give additional written or oral notice to the employer that the employee is com-
28 mencing a period of family leave.

29 (6) Any violation of this section is an unlawful employment practice.

30 (7) This section applies only to employers who employ six or more persons.

31 **SECTION 57.** ORS 659A.049 is amended to read:

32 659A.049. The rights of reinstatement **and reemployment** afforded by ORS 659A.043 and
33 659A.046 shall not be forfeited if the worker refuses to return to the worker's regular or other of-
34 fered employment without release to such employment by the worker's attending physician **as de-**
35 **defined in ORS 656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical services*
36 *under ORS 656.245*].

37 **SECTION 58.** ORS 659A.063 is amended to read:

38 659A.063. (1) The State of Oregon shall cause group health benefits to continue in effect with
39 respect to that worker and any covered dependents or family members by timely payment of the
40 premium that includes the contribution due from the state under the applicable benefit plan, subject
41 to any premium contribution due from the worker that the worker paid before the occurrence of the
42 injury or illness. If the premium increases or decreases, the State of Oregon and worker contribu-
43 tions shall be adjusted to remain consistent with similarly situated active employees. The State of
44 Oregon shall continue the worker's health benefits in effect until whichever of the following events
45 occurs first:

1 (a) The worker's attending physician **as defined in ORS 656.005 (12)** [*or a nurse practitioner*
2 *authorized to provide compensable medical services under ORS 656.245*] has determined the worker
3 to be medically stationary and a notice of closure has been entered;

4 (b) The worker returns to work for the State of Oregon, after a period of continued coverage
5 under this section, and satisfies any probationary or minimum work requirement to be eligible for
6 group health benefits;

7 (c) The worker takes full- or part-time employment with another employer that is comparable in
8 terms of the number of hours per week the worker was employed with the State of Oregon or the
9 worker retires;

10 (d) Twelve months have elapsed since the date the State of Oregon received notice that the
11 worker filed a workers' compensation claim pursuant to ORS chapter 656;

12 (e) The claim is denied and the claimant fails to appeal within the time provided by ORS 656.319
13 or the Workers' Compensation Board or a workers' compensation hearings referee or a court issues
14 an order finding the claim is not compensable;

15 (f) The worker does not pay the required premium or portion thereof in a timely manner in ac-
16 cordance with the terms and conditions under this section;

17 (g) The worker elects to discontinue coverage under this section and notifies the State of
18 Oregon in writing of this election;

19 (h) The worker's attending physician [*or a nurse practitioner authorized to provide compensable*
20 *medical services under ORS 656.245*] has released the worker to modified or regular work, the work
21 has been offered to the worker and the worker refuses to return to work; or

22 (i) The worker has been terminated from employment for reasons unrelated to the workers'
23 compensation claim.

24 (2) If the workers' compensation claim of a worker for whom health benefits are provided pur-
25 suant to subsection (1) of this section is denied and the worker does not appeal or the worker ap-
26 peals and does not prevail, the State of Oregon may recover from the worker the amount of the
27 premiums plus interest at the rate authorized by ORS 82.010. The State of Oregon may recover the
28 payments through a payroll deduction not to exceed 10 percent of gross pay for each pay period.

29 (3) The State of Oregon shall notify the worker of the provisions of ORS 659A.060 to 659A.069,
30 and of the remedies available for breaches of ORS 659A.060 to 659A.069, within a reasonable time
31 after the State of Oregon receives notice that the worker will be absent from work as a result of
32 an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter
33 656. The notice from the State of Oregon shall include the terms and conditions of the continuation
34 of health benefits and what events will terminate the coverage.

35 (4) If the worker fails to make timely payment of any premium contribution owing, the State of
36 Oregon shall notify the worker of impending cancellation of the health benefits and provide the
37 worker with 30 days to pay the required premium prior to canceling the policy.

38 (5) It is an unlawful employment practice for the State of Oregon to discriminate against a
39 worker, as defined in ORS 659A.060, by terminating the worker's group health benefits while that
40 worker is absent from the place of employment as a result of an injury or illness for which a
41 workers' compensation claim has been filed pursuant to ORS chapter 656, except as provided for in
42 this section.

43 **SECTION 59.** ORS 657.170 is amended to read:

44 657.170. (1) If the Director of the Employment Department finds that during the base year of the
45 individual any individual has been incapable of work during the greater part of any calendar quar-

1 ter, such base year shall be extended a calendar quarter. Except as provided in subsection (2) of
2 this section, no such extension of an individual's base year shall exceed four calendar quarters.

3 (2) If the director finds that during and prior to the individual's base year the individual has
4 had a period of temporary total disability caused by illness or injury and has received compensation
5 under ORS chapter 656 for a period of temporary total disability during the greater part of any
6 calendar quarter, the individual's base year shall be extended as many calendar quarters as neces-
7 sary to establish a valid claim, up to a maximum of four calendar quarters prior to the quarter in
8 which the illness or injury occurred, if the individual:

9 (a) Files a claim for benefits not later than the fourth calendar week of unemployment following
10 whichever is the latest of the following dates:

11 (A) The date the individual is released to return to work by the attending physician[, *as defined*
12 *in ORS chapter 656, or a nurse practitioner authorized to provide compensable medical services under*
13 *ORS 656.245*] **as defined in ORS 656.005 (12)**; or

14 (B) The date of mailing of a notice of claim closure pursuant to ORS chapter 656; and

15 (b) Files such a claim within the three-year period immediately following the commencement of
16 such period of illness or injury.

17 (3) Notwithstanding the provisions of this section, benefits payable as a result of the use of
18 wages paid in a calendar quarter prior to the individual's current base year shall not exceed one-
19 third of such wages less benefits paid previously as a result of the use of such wages in computing
20 a previous benefit determination.

21
22 **CAPTIONS**

23
24 **SECTION 60. The unit captions used in this 2026 Act are provided only for the conven-**
25 **ience of the reader and do not become part of the statutory law of this state or express any**
26 **legislative intent in the enactment of this 2026 Act.**

27
28 **EFFECTIVE DATE**

29
30 **SECTION 61. This 2026 Act being necessary for the immediate preservation of the public**
31 **peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect**
32 **on its passage.**

33 _____