

HOUSE AMENDMENTS TO HOUSE BILL 4040

By COMMITTEE ON HEALTH CARE

February 16

1 On page 2 of the printed bill, line 1, after “provisions;” delete the rest of the line and lines 2
2 through 6 and insert “amending ORS 411.447, 414.211, 414.690, 427.191, 442.615, 475A.325, 475A.338,
3 475A.372, 646A.694, 656.005, 656.214, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340,
4 656.726, 656.797, 657.170, 659A.043, 659A.046, 659A.049, 659A.063, 678.733, 679.025, 685.100, 685.102,
5 743A.145, 743B.456, 744.702, 750.055 and 750.333 and section 5, chapter 575, Oregon Laws 2015; re-
6 pealing ORS 743B.221; and declaring an emergency.”.

7 Delete lines 8 through 45 and delete pages 3 through 75 and insert:

“HOSPITALS

11 “**SECTION 1.** ORS 442.615 is amended to read:

12 “442.615. (1) As used in this section:

13 “(a) ‘Financial assistance’ includes:

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

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

16 “(b) ‘Hospital’ has the meaning given that term in ORS 442.612.

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

20 “(a) Is uninsured;

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

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

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

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

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

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

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

33 “(4) A patient may apply for financial assistance:

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

1 fered;

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

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

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

7 “(6) If a patient applies for financial assistance after having paid for the services and the patient
8 is found to have been eligible for financial assistance when the services were provided:

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

10 “(b) If the hospital previously determined, incorrectly, that the patient did not qualify for fi-
11 nancial assistance for the services based on information provided by the patient at the time of the
12 incorrect determination, the hospital shall also pay the patient interest on the amount of financial
13 assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such
14 as legal expenses and fees, incurred by the patient in securing financial assistance; and

15 “(c) If the hospital sold the debt to a collection agency or authorized a collection agency to
16 collect debts on behalf of the hospital, the hospital shall notify the collection agency that the debt
17 is invalid.

18 “(7) If a patient applies for financial assistance and the hospital determines that the patient is
19 eligible for financial assistance based on documentation provided by the patient, the patient’s eli-
20 gibility for financial assistance continues for nine months following the hospital’s determination, and
21 the patient may not be required to reapply for financial assistance for services provided during that
22 nine-month period.

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

29 “(b) If a hospital denies a patient’s application for financial assistance, whether in whole or in
30 part, the hospital must notify the patient of the denial and include in the notice an explanation of
31 the hospital’s appeal process.

32 “(9) During the pendency of an appeal that is filed using a hospital’s appeal process under sub-
33 section (8) of this section, if:

34 “(a) The hospital has initiated collection activities, the hospital must suspend all collection ac-
35 tivities; and

36 “(b) The hospital sold the debt under appeal to a collection agency or has authorized a col-
37 lection agency to collect debts on behalf of the hospital, the hospital must notify the collection
38 agency to suspend collection activities.

39
40 **“RESIDENTIAL CARE**

41
42 **“SECTION 2.** ORS 678.733 is amended to read:

43 **“678.733. (1) The Health Licensing Office may issue a residential care facility administrator li-**
44 **cense to an applicant who:**

45 **“(a) Is at least 21 years of age;**

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

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

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

6 “(C) Graduation from a post-secondary institution;

7 “(c)(A) For at least two of the last five years has been employed in a professional or managerial
8 capacity in a health or social service related field, or has a combination of experience and education
9 deemed sufficient by the office; or

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

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

12 “(e) Pays a licensure fee; and

13 “(f) Passes an examination described in ORS 678.743.

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

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

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

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

24 “**(2) The Health Licensing Office make take any action before the operative date specified
25 in subsection (1) of this section that is necessary to enable the office to exercise, on and
26 after the operative date specified in subsection (1) of this section, all of the duties, functions
27 and powers conferred on the office by the amendments to ORS 678.733 by section 2 of this
28 2026 Act.**

30 “MEDICAL ASSISTANCE

31
32 “**SECTION 5.** ORS 411.447 is amended to read:

33 “411.447. (1) As used in this section, ‘correctional facility’ means:

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

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

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

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

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

40 “**(b)** Enroll the person in the appropriate benefits package based on the person’s eligibility
41 for prerelease benefits, as authorized by federal law.

42 “(3) Upon notification that a person described in subsection (2) of this section is not residing in
43 a correctional facility or that the person is admitted to a medical institution outside of the
44 correctional facility for a period of hospitalization, the department or the authority shall reinstate
45 the [*person’s medical assistance if the person is eligible for medical assistance*] **medical assistance**

1 **benefits for which the person is eligible at the time of release or hospitalization.**

2 “(4)(a) A designee of a correctional facility may apply for medical assistance on behalf of a
3 person, while the person is residing in the correctional facility, for the purpose of establishing el-
4 igibility for medical assistance **prior to release, with full benefits** upon the person’s release from
5 the correctional facility or during a period of hospitalization that will occur outside of the
6 correctional facility.

7 “(b) The designee may obtain information necessary to determine eligibility for medical assist-
8 ance, including the person’s Social Security number or information that is not otherwise subject to
9 disclosure under ORS 411.320 or 413.175. The information obtained under this paragraph may be
10 used only for the purpose of assisting the person in applying for medical assistance and may not be
11 redisclosed without the person’s authorization.

12 “[*c*] *If the person is determined eligible for medical assistance, the effective date of the person’s*
13 *medical assistance shall be the date the person is released from the correctional facility or the date the*
14 *person begins the period of hospitalization outside of the correctional facility.*]

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

17 “**SECTION 6.** ORS 414.690 is amended to read:

18 “414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and in-
19 formation from stakeholders representing consumers, advocates, providers, carriers and employers
20 in conducting the work of the commission.

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

23 “(A) **The agenda for the meeting; and**

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

26 “(i) **A drug or drug class review;**

27 “(ii) **A technology review; and**

28 “(iii) **Coverage guidance.**

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

31 “[2] (3)(a) The commission shall actively solicit public involvement through a public meeting
32 process to guide health resource allocation decisions [*that includes, but is not limited to:*], **in which**
33 **the public is invited to testify in writing and in person. Except when more than 50 written**
34 **comments from the public are received, the authority shall post to the commission’s website**
35 **and provide each commission member with the written comments received from the public**
36 **no later than 48 hours after the close of the public comment period.**

37 “(b) **The public meeting process described in this subsection shall include, but not be**
38 **limited to:**

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

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

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

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

4 “(A) Whether a service is cost-effective;

5 “(B) Whether a service is recommended; or

6 “(C) The value of a service.

7 “(c) The list must be submitted by the commission pursuant to subsection [(5)] (6) of this section
8 and is not subject to alteration by any other state agency.

9 “[4] (5) In order to encourage effective and efficient medical evaluation and treatment, the
10 commission:

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

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

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

20 “[5] (6) The commission shall report the prioritized list of services to the Oregon Health Au-
21 thority for budget determinations by July 1 of each even-numbered year.

22 “[6] (7) The commission shall make its report during each regular session of the Legislative
23 Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Rep-
24 resentatives and the President of the Senate and post to the Oregon Health Authority’s website,
25 along with a solicitation of public comment, an assessment of the impact on access to medically
26 necessary treatment and services by persons with disabilities or chronic illnesses resulting from the
27 commission’s prior use of any quality of life in general measures or any research or analysis that
28 referred to or relied upon a quality of life in general measure.

29 “[7] (8) The commission may alter the list during the interim only as follows:

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

31 “(b) To accommodate changes due to advancements in medical technology or new data regarding
32 health outcomes;

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

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

35 “[8] (9) If a service is deleted or added during an interim and no new funding is required, the
36 commission shall report to the Speaker of the House of Representatives and the President of the
37 Senate. However, if a service to be added requires increased funding to avoid discontinuing another
38 service, the commission shall report to the Emergency Board to request the funding.

39 “[9] (10) The prioritized list of services remains in effect for a two-year period beginning no
40 earlier than October 1 of each odd-numbered year.

41 “[10](a) (11)(a) As used in this section, ‘peer-reviewed medical literature’ means scientific
42 studies printed in journals or other publications that publish original manuscripts only after the
43 manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy,
44 validity and reliability.

45 “(b) ‘Peer-reviewed medical literature’ does not include internal publications of pharmaceutical

1 manufacturers.

2 **“SECTION 7.** ORS 414.211 is amended to read:

3 “414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than
4 15 members appointed by the Governor.

5 “(2) The committee shall be composed of:

6 “(a) A physician licensed under ORS chapter 677;

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

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

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

13 “(e) The Director of Human Services or designee;

14 “(f) Health care providers;

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

17 “(h) Members of the general public.

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

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

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

26 **“SECTION 8. The amendments to ORS 414.211 by section 7 of this 2026 Act become op-**
27 **erative on July 10, 2027.**

28 **“SECTION 9. Notwithstanding ORS 414.211, the Medicaid Advisory Committee shall be**
29 **composed of:**

30 **“(1) For the period between the effective date of this 2026 Act and July 9, 2026, at least**
31 **10 percent Medicaid recipients; and**

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

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

35
36 **“PARENT PROVIDERS**

37
38 **“SECTION 11.** ORS 427.191 is amended to read:

39 “427.191. (1) As used in this section:

40 “(a) ‘Agency’ means an agency that hires, trains and supervises direct support professionals us-
41 ing state funds received from the Department of Human Services.

42 “(b) ‘Attendant care services’ means services provided directly to an individual with a disability
43 to assist with activities of daily living, instrumental activities of daily living and health-related
44 tasks.

45 “(c) ‘Child’ means an individual under 18 years of age who:

1 “(A) Has a developmental or intellectual disability; or
2 “(B) Meets the eligibility criteria to receive services under the Medically Fragile (Hospital)
3 Model Waiver or the Medically Involved Children’s Waiver approved by the Centers for Medicare
4 and Medicaid Services under 42 U.S.C. 1396n(c).
5 “(d) ‘Client’ means an individual who receives attendant care services.
6 “(e) ‘Client child’ means a child who receives attendant care services from the child’s parent.
7 “(f) ‘Developmental disability services’ has the meaning given that term in ORS 427.101.
8 “(g) ‘Direct support professional’ means an individual who is hired, employed, trained, paid and
9 supervised by an agency to provide attendant care services to a client of the agency.
10 “(h) ‘Nonparent caregiver’ means a direct support professional, personal support worker or
11 similar provider who is paid to provide attendant care services to clients who are not the provider’s
12 children.
13 “(i) ‘Parent’ includes a:
14 “(A) Natural or adoptive parent of a child;
15 “(B) Stepparent of a child; and
16 “(C) Legal guardian of a child.
17 “(j)(A) ‘Parent provider’ means a parent who is paid to provide attendant care services to the
18 parent’s minor child.
19 “(B) ‘Parent provider’ does not include a parent who is paid to provide attendant care services
20 to a child who is 18 years of age or older.
21 “(k)(A) ‘Personal support worker’ means an individual who is employed by a client or the client’s
22 representative and paid to provide attendant care services to the client.
23 “(B) ‘Personal support worker’ does not include a direct support professional.
24 “(L) ‘State plan’ means Oregon’s state plan for medical assistance, described in 42 U.S.C. 1396a,
25 approved by the Centers for Medicare and Medicaid Services.
26 “(m) ‘Very high behavioral needs’ means a minor child’s extraordinary needs for support due to
27 the child’s behavioral condition as indicated by a federally approved functional needs assessment
28 adopted by the department that assigns the child to the highest service level.
29 “(n) ‘Very high medical needs’ means a minor child’s extraordinary needs for support due to the
30 child’s medical condition as indicated by a federally approved functional needs assessment adopted
31 by the department that assigns the child to the highest service level.
32 “(2) Subject to rules adopted under subsection (8) of this section, to ORS 427.194 and to avail-
33 able funding, the department shall administer a program to compensate parents to provide attendant
34 care services to the parents’ children who have been assessed by the department to have very high
35 medical or very high behavioral needs.
36 “(3) To be eligible for the program described in this section:
37 “(a) A parent provider must be employed [*by an agency and not by the child or the other parent*
38 *of the child*] **as a direct support professional or a personal support worker**;
39 “(b) The parent provider may not be paid to provide attendant care services to the client child
40 by an agency that is owned by the parent, the **client** child or any family member or for which the
41 parent or other family member serves in any administrative or leadership capacity, including as a
42 member of a board of directors; and
43 “(c) The agency employing the parent provider to provide attendant care services to the client
44 child:
45 “(A) May not employ a parent provider as an independent contractor;

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

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

7 “(D) May not pay providers of attendant care services, including parent providers, to provide
8 services to a [*minor*] child during school hours due to the determination of a school district or due
9 to the choice of a parent of the [*client*] child to:

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

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

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

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

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

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

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

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

29 “(A) Grocery shopping for the household;

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

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

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

33 “(6) If required by the Centers for Medicare and Medicaid Services, the department may require
34 a parent provider to assign an alternative legal representative for the client child to make decisions
35 about or manage the development and implementation of the client child’s individual support plan.
36 The assignment:

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

38 “(b) Must clearly state that the assignment is limited to decisions regarding the development
39 and implementation of the **client** child’s individual support plan and does not limit the authority of
40 the parent provider to make decisions for the client child with respect to health care, education or
41 religious training.

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

44 “(8) The department shall adopt rules for the program described in this section using an advi-
45 sory committee appointed under ORS 183.333 that represents the interests of parents, children with

1 developmental or intellectual disabilities, adults with disabilities, agencies, organizations of direct
2 support professionals and personal support workers and organizations that advocate for persons with
3 disabilities. The rules must include all of the following:

4 “(a) Strategies to safeguard nonparent caregivers and avoid the displacement of nonparent
5 caregivers by parent providers;

6 “(b) Requirements for agencies to demonstrate consistent efforts to recruit, train and retain
7 nonparent caregivers;

8 “(c) **Requirements for appropriate training, background checks and oversight, including**
9 **training requirements for:**

10 “(A) Parent providers regarding federal and state administrative rules regulating home-based
11 and community-based services, including the impact of the rules on parent-child relationships with
12 respect to discipline, supervision, physical intervention and self-determination of client children
13 during the hours that the parent provider is being paid to provide attendant care services;

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

16 “(C) Community developmental disability programs related to the employment of parent provid-
17 ers, including on how to support families to manage issues concerning conflicts of interest, provider
18 recruitment and retention and the empowerment of the client child to have a meaningful voice in
19 the selection of the client child’s *[direct support professionals]* **caregivers;**

20 “(d) A process for a client child to object to the hiring of any caregiver, including the child’s
21 parent, or to raise concerns about a provider’s caregiving;

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

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

26 “(g) **Procedures to ensure program integrity and prevent duplicate payment for the same**
27 **service hours;** and

28 “[g] (h) Other requirements that the department deems necessary to carry out the provisions
29 of this section.

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

35 “(10) Annually, the department shall report to the interim committees of the Legislative As-
36 sembly related to human services or, if the Legislative Assembly is in session, to the committees of
37 the Legislative Assembly related to human services, in the manner provided in ORS 192.245, updates
38 on the program described in this section, including:

39 “(a) The number of client children receiving attendant care services, the number of children
40 receiving the services from parent providers and the number of children receiving the services from
41 nonparent caregivers;

42 “(b) The number of hours of attendant care services provided by parent providers and number
43 of hours of attendant care services provided by nonparent caregivers;

44 “(c) A comparison of the cost per child of providing attendant care services by parent providers
45 under the program with the cost per child of providing attendant care services by nonparent

1 caregivers; and

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

4
5 “**DENTAL**

6
7 “**SECTION 12.** ORS 679.025 is amended to read:

8 “679.025. (1) A person may not practice dentistry or purport to be a dentist without a valid li-
9 cense to practice dentistry issued by the Oregon Board of Dentistry.

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

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

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

20 “(c) Bona fide full-time students of dentistry who, during the period of their enrollment and as
21 a part of the course of study in a dental education program located outside of Oregon that is ac-
22 credited by the Commission on Dental Accreditation of the American Dental Association or its
23 successor [*agency*] **organization**, engage in community-based or clinical studies as an elective or
24 required rotation in a clinical setting located in Oregon if the community-based or clinical studies
25 meet minimum requirements prescribed by the rules of the board and are performed under the indi-
26 rect supervision of a [*member of the faculty of the Oregon Health and Science University School of*
27 *Dentistry*] **faculty member of a dental education program accredited by the Commission on**
28 **Dental Accreditation of the American Dental Association, or its successor organization.**

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

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

36 “(f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching
37 activities and while employed in accredited dental educational institutions.

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

40 “(h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of
41 their duties.

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

44 “(j)(A) Dentists licensed in another country and in good standing, while practicing dentistry
45 without compensation for no more than five consecutive days in any 12-month period, provided the

1 dentist submits an application to the board at least 10 days before practicing dentistry under this
2 subparagraph and the application is approved by the board.

3 “(B) Dentists licensed in another state or United States territory and practicing in this state
4 under ORS 676.347.

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

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

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

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

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

14 “**(2) The Oregon Board of Dentistry make take any action before the operative date**
15 **specified in subsection (1) of this section that is necessary to enable the board to exercise,**
16 **on and after the operative date specified in subsection (1) of this section, all of the duties,**
17 **functions and powers conferred on the board by the amendments to ORS 679.025 by section**
18 **12 of this 2026 Act.**

19
20 “**COMMERCIAL HEALTH INSURANCE**

21
22 “**SECTION 14.** **Section 15 of this 2026 Act is added to and made a part of the Insurance**
23 **Code.**

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

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

31 “**SECTION 16.** **Section 15 of this 2026 Act applies to group or individual policies of casu-**
32 **alty insurance or health insurance, including health benefit plans, that are issued, renewed**
33 **or extended on or after January 1, 2027.**

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

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

37 “**(1) ‘Dental insurance plan’ means a policy or certificate of insurance or other contract**
38 **that provides only a dental benefit.**

39 “**(2) ‘Dental insurer’ means an insurer that offers a policy or certificate of insurance or**
40 **other contract that provides only a dental benefit.**

41 “**(3) ‘Dental provider’ means a person licensed, certified or otherwise permitted by laws**
42 **of this state to administer dental services in the ordinary course of business or practice of**
43 **a profession.**

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

45 “**743B.456. (1) As used in this section, [‘dental insurer’ means an insurer that offers a policy or**

1 *certificate of insurance or other contract, that provides only a dental benefit]* **‘clean claim’ means a**
2 **claim that has no defect or error, is understandable and reasonably legible, includes required**
3 **substantiating documentation and does not require special treatment that delays timely**
4 **payment on the claim.**

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

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

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

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

14 “(3) If a dental insurer contracts with a vendor to process payments of dental providers’ claims,
15 the dental insurer shall require the vendor to comply with the provisions of subsection (2)(a) of this
16 section.

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

27 “(5) A contract between a dental insurer and a dental provider may not include a pro-
28 vision governing payment of claims that limits the rights and remedies available to a pro-
29 vider under this section or has the effect of relieving either party of its obligations under
30 this section.

31 “(6) A dental insurer shall establish a method of communicating to dental providers the
32 procedures and information necessary to complete claim forms. The procedures and infor-
33 mation must be reasonably accessible to dental providers.

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

35 “SECTION 20. (1) As used in this section, ‘refund’ means the return, either directly or
36 through an offset to a future claim, of some or all of a payment already received by a dental
37 provider.

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

40 “(a) Request from a dental provider a refund of a payment previously made to satisfy a
41 claim unless the dental insurer:

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

45 “(B) Specifies in the written or electronic request why the dental insurer believes the

1 dental provider owes the refund.

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

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

6 “(a) Request from a dental provider a refund of a payment previously made to satisfy a
7 claim unless the dental insurer:

8 “(A) Requests the refund in writing or electronically within 45 days after the date the
9 payment was made;

10 “(B) Specifies in the written or electronic request why the dental insurer believes the
11 provider owes the refund; and

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

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

16 “(4) If a dental provider fails to contest a refund request in writing or electronically to
17 the dental insurer within 30 days after receiving the request, the request is deemed accepted
18 and the dental provider must pay the refund within 30 days after the request is deemed ac-
19 cepted. If the dental provider has not paid the refund within 30 days after the request is
20 deemed accepted, the dental insurer may recover the amount through an offset to a future
21 claim.

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

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

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

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

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

37 “SECTION 21. A dental provider that bills a dental insurer for covered services provided
38 to an individual who is insured under a dental insurance plan shall be reimbursed by the
39 insurer by a direct payment issued to the dental provider.

40 “SECTION 22. Sections 18, 20 and 21 of this 2026 Act and the amendments to ORS
41 743B.456 by section 19 of this 2026 Act become operative on January 1, 2028.

42 “SECTION 23. (1) As used in this section and section 24 of this 2026 Act, ‘insurance
43 coverage mandate’ means a proposed legislative measure that requires payment for certain
44 services of health care providers or that requires an offering of health insurance coverage
45 by an insurer or a health care service contractor as a component of an individual or group

1 health insurance policy.

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

5 “(a) Sources of data to be considered in the preparation of an insurance coverage man-
6 date impact statement for proposed legislation; and

7 “(b) Sources of research to be considered in the preparation of an insurance coverage
8 mandate impact statement.

9 “(3) In preparing the template, the director shall consider models used in other states
10 and in academic research for assessing the impacts of proposed insurance coverage mandate
11 legislation and other formal actions undertaken by national, state and local government en-
12 tities and other entities in the United States, including educational institutions.

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

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

23 “(a) The template methodology and review process;

24 “(b) The director’s experience in preparing draft impact statements; and

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

26 “(6) Based on feedback provided by the committees with jurisdiction over health care, the
27 director may modify the template and prepare final insurance coverage mandate impact
28 statements on the test measures. The director shall present the final impact statements and
29 the final process report summarizing the methodology used to prepare and review impact
30 statements to the policy committees that had heard the test measures during the 2025 reg-
31 ular session of the Legislative Assembly. The director shall present the statements and final
32 report to the committees on or before December 15, 2026.

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

44 “SECTION 24. An insurance coverage mandate impact statement required to be devel-
45 oped under section 23 of this 2026 Act shall include but need not be limited to the following:

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

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

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

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

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

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

13 “(7) The extent to which the coverage in the proposed measure is already provided by the
14 Public Employees’ Benefit Board, the Oregon Educators Benefit Board or individual, small
15 employer group and large employer group health insurance plans;

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

19 “(9) The extent to which a lack of the coverage in the proposed measure results in fi-
20 nancial hardship to residents of this state.

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

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

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

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

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

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

34 “**SECTION 28.** ORS 750.055 is amended to read:

35 “750.055. (1) The following provisions apply to health care service contractors to the extent not
36 inconsistent with the express provisions of ORS 750.005 to 750.095:

37 “(a) ORS 705.137, 705.138 and 705.139.

38 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
39 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
40 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
41 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

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

44 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
45 to 733.780.

1 “(e) ORS 734.014 to 734.440.

2 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
3 742.542.

4 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
5 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
6 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
7 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

8 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
9 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
10 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
11 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
12 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
13 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

14 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
15 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
16 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
17 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
18 743B.407, 743B.420, 743B.423, 743B.430, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475,
19 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and 743B.800.

20 “(j) The following provisions of ORS chapter 744:

21 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
22 ducers;

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

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

25 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,
26 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and
27 746.690.

28 “(2) The following provisions of the Insurance Code apply to health care service contractors
29 except in the case of group practice health maintenance organizations that are federally qualified
30 pursuant to Title XIII of the Public Health Service Act:

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

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

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

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

39 “(5)(a) A health care service contractor is a domestic insurance company for the purpose of
40 determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

41 “(b) A health care service contractor’s classification as a domestic insurance company under
42 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
43 to 734.710.

44 “(6) The Director of the Department of Consumer and Business Services may, after notice and
45 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025

1 and 750.045 that are necessary for the proper administration of these provisions.

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

4 “750.055. (1) The following provisions apply to health care service contractors to the extent not
5 inconsistent with the express provisions of ORS 750.005 to 750.095:

6 “(a) ORS 705.137, 705.138 and 705.139.

7 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
8 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
9 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
10 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

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

13 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
14 to 733.780.

15 “(e) ORS 734.014 to 734.440.

16 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
17 742.542.

18 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
19 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
20 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
21 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

22 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
23 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
24 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
25 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
26 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
27 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

28 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
29 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
30 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
31 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
32 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
33 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
34 743B.800.

35 “(j) The following provisions of ORS chapter 744:

36 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
37 ducers;

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

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

40 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,
41 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and
42 746.690.

43 “(2) The following provisions of the Insurance Code apply to health care service contractors
44 except in the case of group practice health maintenance organizations that are federally qualified
45 pursuant to Title XIII of the Public Health Service Act:

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

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

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

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

9 “(5)(a) A health care service contractor is a domestic insurance company for the purpose of
10 determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

11 “(b) A health care service contractor’s classification as a domestic insurance company under
12 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
13 to 734.710.

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

17 “**SECTION 30.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
18 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
19 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
20 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
21 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
22 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
23 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,
24 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
25 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
26 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
27 2024, section 22, chapter 70, Oregon Laws 2024, section 163, chapter 73, Oregon Laws 2024, sections
28 6 and 8, chapter 388, Oregon Laws 2025, section 6, chapter 536, Oregon Laws 2025, and section 19,
29 chapter 539, Oregon Laws 2025, is amended to read:

30 “750.055. (1) The following provisions apply to health care service contractors to the extent not
31 inconsistent with the express provisions of ORS 750.005 to 750.095:

32 “(a) ORS 705.137, 705.138 and 705.139.

33 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
34 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
35 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
36 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

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

39 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
40 to 733.780.

41 “(e) ORS 734.014 to 734.440.

42 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
43 742.542.

44 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
45 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,

1 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
2 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

3 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
4 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
5 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
6 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
7 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
8 743A.260, 743A.310 and 743A.315.

9 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
10 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
11 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
12 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
13 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
14 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
15 743B.800.

16 “(j) The following provisions of ORS chapter 744:

17 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
18 ducers;

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

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

21 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,
22 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and
23 746.690.

24 “(2) The following provisions of the Insurance Code apply to health care service contractors
25 except in the case of group practice health maintenance organizations that are federally qualified
26 pursuant to Title XIII of the Public Health Service Act:

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

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

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

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

35 “(5)(a) A health care service contractor is a domestic insurance company for the purpose of
36 determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

37 “(b) A health care service contractor’s classification as a domestic insurance company under
38 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
39 to 734.710.

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

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

44 “750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
45 arrangement:

1 “(a) ORS 705.137, 705.138 and 705.139.

2 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
3 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
4 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
5 731.992.

6 “(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.

7 “(d) ORS 734.014 to 734.440.

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

9 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
10 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and 743B.221*].

11 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
12 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
13 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
14 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
15 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
16 743A.252, 743A.260 and 743A.310.

17 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
18 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
19 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
20 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
21 743B.423, 743B.430, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601, 743B.607
22 and 743B.610.

23 “(i) The following provisions of ORS chapter 744:

24 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
25 ducers;

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

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

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

29 “(2) For the purposes of this section:

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

31 “(b) References to certificates of authority are references to certificates of multiple employer
32 welfare arrangement.

33 “(c) Contributions are premiums.

34 “(3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
35 insurance.

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

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

40 “750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
41 arrangement:

42 “(a) ORS 705.137, 705.138 and 705.139.

43 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
44 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
45 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to

1 731.992.

2 “(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.

3 “(d) ORS 734.014 to 734.440.

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

5 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
6 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and* 743B.221].

7 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
8 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
9 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
10 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
11 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
12 743A.252, 743A.260 and 743A.310.

13 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
14 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
15 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
16 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
17 743B.423, 743B.430, 743B.445, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601,
18 743B.607 and 743B.610.

19 “(i) The following provisions of ORS chapter 744:

20 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
21 ducers;

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

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

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

25 “(2) For the purposes of this section:

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

27 “(b) References to certificates of authority are references to certificates of multiple employer
28 welfare arrangement.

29 “(c) Contributions are premiums.

30 “(3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
31 insurance.

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

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

35 “743A.145. (1) As used in this section:

36 “(a) ‘Device’ means:

37 “(A) An orthotic device.

38 “(B) A prosthetic device.

39 “(b) ‘Orthotic device’ means a rigid or semirigid device supporting a weak or deformed leg, foot,
40 arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm,
41 hand, back or neck.

42 “(c) ‘Prosthetic device’ means an artificial limb device or appliance designed to replace in whole
43 or in part an arm or a leg.

44 “(2) All individual and group health insurance policies providing coverage for the expenses of
45 hospital, medical or surgical services or supplies shall provide coverage for devices. The coverage

1 required by this subsection includes:

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

5 “(b) All services and supplies medically necessary for the effective use of a device, including
6 design formulation, fabrication, material and component selection, measurements, fittings, static and
7 dynamic alignments and patient instruction in the use of the device.

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

10 “(A) A change in the physiological condition of the insured;

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

12 “(C) The device, or a part of the device, requiring repair and the cost of the repair would be
13 more than 60 percent of the cost of the replacement device or replacement part of the device.

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

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

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

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

22 “(3) The Director of the Department of Consumer and Business Services shall adopt and annu-
23 ally update rules listing the devices covered under this section. The list shall be no more restrictive
24 than the list of devices and supplies in the Medicare fee schedule for Durable Medical Equipment,
25 Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

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

29 “(5) If the coverage under subsection (2) of this section is provided through a managed care
30 organization, the insured shall have access to medically necessary clinical care and to devices and
31 technology from not fewer than two distinct Oregon prosthetic and orthotic providers in the man-
32 aged care organization’s provider network.

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

38 “(7) For coverage described in subsection (2)(c) of this section, an insurer may require confir-
39 mation from the prescribing health care provider that the coverage is medically necessary if the
40 device, or any part of the device, requires replacement and is less than three years old.

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

42 “(9) The coverage requirements described in subsections (2)(e), (6) and (7) of this section do not
43 apply to a health benefit plan offered by the Public Employees’ Benefit Board or the Oregon Edu-
44 cators Benefit Board, unless the plans offered by the Public Employees’ Benefit Board or the Oregon
45 Educators Benefit Board elect to provide the coverage and provide notice to the Department of

1 Consumer and Business Services in the form and manner described by the department by rule.

2
3 **“PHARMACY**

4
5 **“SECTION 34.** ORS 744.702 is amended to read:

6 “744.702. (1) Subject to ORS 744.704, a person shall not transact business or purport or offer to
7 transact business as a third party administrator in this state unless the person holds a third party
8 administrator license issued by the Director of the Department of Consumer and Business Services.

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

11 “(a) Directly or indirectly solicits or effects coverage of, underwrites, collects charges or pre-
12 miums from, or adjusts or settles claims on, residents of this state or residents of another state from
13 offices in this state, in connection with life insurance or health insurance coverage; or

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

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

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

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

27 “646A.694. (1) The Department of Consumer and Business Services shall provide to the Pre-
28 scription Drug Affordability Board each calendar year a list of prescription drugs included in re-
29 ports submitted to the department under ORS 646A.689 (2) and (6), a list of drugs included in reports
30 submitted to the department under ORS 646A.683 and 743.025 and a list of insulin drugs marketed
31 in this state during the previous calendar year. Each calendar year, the board shall identify up to
32 nine drugs and **may identify** at least one insulin product from the lists provided under this sub-
33 section that the board determines may create affordability challenges for health care systems or
34 high out-of-pocket costs for patients in this state based on criteria adopted by the board by rule,
35 including but not limited to:

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

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

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

39 “(d) The estimated average monetary price concession, discount or rebate the manufacturer
40 provides to health insurance plans in this state or is expected to provide to health insurance plans
41 in this state, expressed as a percentage of the price for the prescription drug under review;

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

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

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

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

7 “(i) The impact on patient access to the drug considering standard prescription drug benefit
8 designs in health insurance plans offered in this state;

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

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

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

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

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

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

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

27 “(b) As used in this subsection:

28 “(A) ‘Health utility’ means a measure of the degree to which having a particular form of disease
29 or disability or having particular functional limitations negatively impacts the quality of life as
30 compared to a state of perfect health, expressed as a number between zero and one.

31 “(B) ‘Quality-adjusted life-year’ is the product of a health utility multiplied by the extra months
32 or years of life that a patient might gain as a result of a treatment.

33 “(5) To the extent practicable, the board shall access pricing information for prescription drugs
34 by:

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

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

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

39 “(d) Accessing other publicly available pricing information.

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

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

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

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

3
4 “PSILOCYBIN

5
6 “**SECTION 36.** ORS 475A.325 is amended to read:

7 “475A.325. [*Facilitator license; fees; rules.*] (1) The facilitation of psilocybin services is subject
8 to regulation by the Oregon Health Authority.

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

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

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

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

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

16 “[*(e)*] (d) [*Must*] Submit evidence of completion of education and training prescribed and ap-
17 proved by the authority;

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

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

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

24 “(4) The authority shall adopt rules that:

25 “(a) Require a psilocybin service facilitator to annually renew a license issued under this sec-
26 tion;

27 “(b) Establish application, licensure and renewal of licensure fees for psilocybin service
28 facilitators; [*and*]

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

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

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

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

40 “(b) Shall be deposited in the Psilocybin Control and Regulation Fund established under ORS
41 475A.492.

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

45 “(7) A license issued to a psilocybin service facilitator under this section is not limited to any

1 one or more premises.

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

3 “475A.338. (1)(a) As used in this subsection, ‘board’ means:

4 “**(A) The Occupational Therapy Licensing Board;**

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

6 “[~~(B)~~] **(C)** The Oregon Board of Naturopathic Medicine;

7 “**(D) The Oregon Board of Physical Therapy;**

8 “[~~(C)~~] **(E)** The Oregon Board of Psychology;

9 “[~~(D)~~] **(F)** The Oregon Medical Board;

10 “[~~(E)~~] **(G)** The Oregon State Board of Nursing;

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

12 “[~~(G)~~] **(I)** The State Board of Pharmacy.

13 “(b) A person who is licensed or otherwise authorized by a board to provide health care or be-
14 havioral health care services and who holds a license under ORS 475A.325 may, in accordance with
15 the provisions of ORS 475A.210 to 475A.722 and rules adopted under ORS 475A.210 to 475A.722:

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

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

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

22 “(a) Discussing with a client or patient, as a treatment option, psilocybin services provided by
23 a psilocybin service facilitator that holds a license issued under ORS 475A.325 at a psilocybin ser-
24 vice center for which a license is issued under ORS 475A.305; or

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

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

30 “475A.372. (1) As used in this section, ‘adverse behavioral reaction’ and ‘adverse medical re-
31 action’ have the meanings given those terms by rule by the Oregon Health Authority.

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

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

35 “(A) The race, ethnicity, preferred spoken and written languages, disability status, sexual ori-
36 entation, gender identity, income, age, veteran status and county of residence of each client; and

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

38 “(b) Compile and maintain the following information that pertains to the three-month period
39 immediately preceding a quarterly submission under subsection (4) of this section:

40 “(A) The number of clients served;

41 “(B) The number of individual administration sessions provided;

42 “(C) The number of group administration sessions provided;

43 “(D) The number of individuals to whom the psilocybin service center or a psilocybin service
44 facilitator practicing at the psilocybin service center denied psilocybin services and the reasons for
45 which psilocybin services were denied;

1 “(E) The number and severity of:
2 “(i) Adverse behavioral reactions experienced by clients, of which the psilocybin service center
3 operator is aware; and
4 “(ii) Adverse medical reactions experienced by clients, of which the psilocybin service center
5 operator is aware; and
6 “(F) Any additional information required by the authority by rule as described in subsection (7)
7 of this section; and
8 “(c) Compute, for the period described in paragraph (b) of this subsection, and maintain the
9 following information:
10 “(A) The average number of times per client that psilocybin services were received;
11 “(B) The average number of clients participating in each group administration session; [and]
12 “(C) **For doses higher than five milligrams of psilocybin analyte, the total average dose of**
13 **psilocybin per client per administration session[.]; and**
14 “(D) **For doses of five milligrams or less of psilocybin analyte, the total average dose of**
15 **psilocybin per client per administration session.**
16 “(3) Pursuant to rules adopted by the authority, a client may request that a psilocybin service
17 center operator not submit to the authority information provided by the client as described in sub-
18 section (2) of this section.
19 “(4) Subject to subsection (3) of this section, a psilocybin service center operator shall aggregate
20 and submit, in a manner that protects the personally identifiable information of a client or individual
21 from whom information is collected, to the authority on a quarterly basis the information described
22 in subsection (2) of this section. The authority may exempt from the submission requirement infor-
23 mation that the authority determines cannot be adequately deidentified.
24 “(5) The authority shall submit the information received under subsection (4) of this section to
25 the Oregon Health and Science University for the purpose of enabling the evaluation of outcomes
26 of psilocybin services provided under ORS 475A.210 to 475A.722.
27 “(6)(a) Except as otherwise required by law, the information collected, maintained and reported
28 under this section is exempt from disclosure under ORS 192.311 to 192.478.
29 “(b) Information collected, computed, maintained or reported under this section may not be sold.
30 “(7) The authority may adopt rules to carry out this section. Rules adopted under this section
31 may include rules to require a psilocybin service center operator to collect and submit to the au-
32 thority information in addition to that described in subsection (2) of this section that, in the dis-
33 cretion of the authority, would be beneficial to understanding the outcomes of psilocybin services
34 provided under ORS 475A.210 to 475A.722.
35 “**SECTION 39. (1) The amendments to ORS 475A.325, 475A.338 and 475A.372 by sections**
36 **36 to 38 of this 2026 Act become operative on January 1, 2027.**
37 “(2) **The Oregon Health Authority, the Occupational Therapy Licensing Board and the**
38 **Oregon Board of Physical Therapy may take any action before the operative date specified**
39 **in subsection (1) of this section that is necessary to enable the authority and the boards to**
40 **exercise, on and after the operative date specified in subsection (1) of this section, all of the**
41 **duties, functions and powers conferred on the authority and the boards by the amendments**
42 **to ORS 475A.325, 475A.338 and 475A.372 by sections 36 to 38 of this 2026 Act.**

43
44 “NATUROPATHIC PHYSICIANS
45

1 “**SECTION 40.** ORS 685.100 is amended to read:

2 “685.100. (1) Upon approval of an application for a licensure, the Oregon Board of Naturopathic
3 Medicine shall issue a license certificate that shall be displayed at all times in the office of the
4 person to whom it was issued while the license is active.

5 “(2) A person holding an active license issued under this chapter may apply to the board for
6 license renewal. A completed renewal application consists of:

7 “(a) A completed board renewal form containing any information required by the board to de-
8 termine the applicant’s eligibility for license renewal;

9 “(b) Proof of compliance with continuing education requirements set by the board; and

10 “(c) Payment of the active license renewal fee established by the board under subsection (8) of
11 this section.

12 “(3) Failure to submit a completed renewal application annually by December 31, or by such
13 date as may be specified by board rule, results in the lapse of the license. A lapsed license may be
14 restored by the board upon receipt, not more than 30 days after the license lapses, of a completed
15 renewal application and payment of the restoration fee under subsection (8) of this section.

16 “(4) A license that has lapsed for more than one month may be restored by the board upon
17 payment of the restoration fee established by the board and submission of a completed renewal ap-
18 plication and any other information required by the board.

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

24 “(6)(a) A person who chooses to allow a license to become inactive may file a written applica-
25 tion to reactivate a license that has been inactive for one year or less by paying the restoration fee
26 and the renewal fee for an active license and demonstrating compliance with ORS 685.102. A fee
27 paid to place the license in inactive status may not be credited toward payment of the renewal fee
28 for an active license. The board may prorate the renewal fee.

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

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

35 “(8) The board shall assess fees for:

36 “(a) An initial license.

37 “(b) Examination.

38 “(c) Renewal of an active license.

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

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

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

42 “(g) A duplicate license.

43 “(h) A wall certificate.

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

45 “(9) Subject to prior approval of the Oregon Department of Administrative Services, the fees and

1 charges established under this section may not exceed the cost of administering the regulatory
2 program of the [board] **Oregon Board of Naturopathic Medicine** pertaining to the purpose for
3 which the fee or charge is established, as authorized by the Legislative Assembly within the board's
4 budget, as the budget may be modified by the Emergency Board.

5 **"SECTION 41.** ORS 685.102 is amended to read:

6 "685.102. (1) Except as provided in subsections (2) and (5) of this section, each person holding
7 a license under this chapter shall submit annually by December 31, evidence satisfactory to the
8 Oregon Board of Naturopathic Medicine of successful completion of an approved program of con-
9 tinuing education of at least 25 hours in naturopathic medicine, completed in the calendar year
10 preceding the date on which the evidence is submitted, and completion during the renewal period,
11 or documentation of completion within the previous 36 months, of:

12 "(a) A pain management education program approved by the board and developed based on
13 recommendations of the Pain Management Commission; or

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

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

20 "(3) Notwithstanding subsection (2) of this section, a person holding a license under this chapter
21 may be exempted from the requirements of subsection (1) of this section upon application showing
22 evidence satisfactory to the board that the applicant is or will be in the next calendar year at least
23 [70] **65** years of age and is retired or will retire in the next calendar year from the practice of
24 naturopathic medicine.

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

28 "(5) A person whose license is in inactive status must submit by December 31 of each year ev-
29 idence satisfactory to the board of completion of 10 hours of approved continuing education in the
30 calendar year preceding the date on which the evidence is submitted.

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

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

36 **"(2) The Oregon Board of Naturopathic Medicine may take any action before the opera-**
37 **tive date specified in subsection (1) of this section that is necessary to enable the board to**
38 **exercise, on and after the operative date specified in subsection (1) of this section, all of the**
39 **duties, functions and powers conferred on the board by the amendments to ORS 685.100 and**
40 **685.102 by sections 40 and 41 of this 2026 Act.**

41
42 **"WORKERS' COMPENSATION RECLASSIFICATION OF**
43 **PHYSICIAN ASSOCIATES AND NURSE PRACTITIONERS**
44

45 **"SECTION 43.** ORS 656.005 is amended to read:

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

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

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

8 “(3) ‘Board’ means the Workers’ Compensation Board.

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

12 “(5) ‘Child’ means a child of an injured worker, including:

13 “(a) A posthumous child;

14 “(b) A child legally adopted before the injury;

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

16 “(d) A child born out of wedlock;

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

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

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

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

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

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

35 “(b) ‘Compensable injury’ does not include:

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

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

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

44 “(c) A ‘disabling compensable injury’ is an injury that entitles the worker to compensation for
45 disability or death. An injury is not disabling if no temporary benefits are due and payable, unless

1 there is a reasonable expectation that permanent disability will result from the injury.

2 “(d) A ‘nondisabling compensable injury’ is any injury that requires medical services only.

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

6 “(9) ‘Department’ means the Department of Consumer and Business Services.

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

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

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

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

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

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

17 “(11) ‘Director’ means the Director of the Department of Consumer and Business Services.

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

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

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

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

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

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

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

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

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

1 paragraph, a:

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

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

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

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

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

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

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

26 “(c) As used in paragraph (b) of this subsection, ‘temporary service provider’ has the meaning
27 given that term in ORS 656.850.

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

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

33 “(15) ‘Consumer and Business Services Fund’ means the fund created by ORS 705.145.

34 “(16) ‘Incapacitated’ means an individual is physically or mentally unable to earn a livelihood.

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

37 “(18) ‘Noncomplying employer’ means a subject employer that has failed to comply with ORS
38 656.017.

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

43 “(20) ‘Palliative care’ means medical service rendered to reduce or moderate temporarily the
44 intensity of an otherwise stable medical condition, but does not include those medical services ren-
45 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

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

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

13 “(23) ‘Person’ includes a partnership, joint venture, association, limited liability company and
14 corporation.

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

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

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

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

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

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

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

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

35 “(26) ‘State Accident Insurance Fund Corporation’ and ‘corporation’ mean the State Accident
36 Insurance Fund Corporation created under ORS 656.752.

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

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

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

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

12 “(29) ‘Independent contractor’ has the meaning given that term in ORS 670.600.

13 “**SECTION 44.** ORS 656.005, as amended by section 22, chapter 78, Oregon Laws 2025, is
14 amended to read:

15 “656.005. (1) ‘Average weekly wage’ means the Oregon average weekly wage in covered em-
16 ployment, as determined by the Employment Department, for the last quarter of the calendar year
17 preceding the fiscal year in which the injury occurred.

18 “(2)(a) ‘Beneficiary’ means an injured worker, and the spouse in a marriage, child or dependent
19 of a worker, who is entitled to receive payments under this chapter.

20 “(b) ‘Beneficiary’ does not include a person who intentionally causes the compensable injury to
21 or death of an injured worker.

22 “(3) ‘Board’ means the Workers’ Compensation Board.

23 “(4) ‘Carrier-insured employer’ means an employer who provides workers’ compensation cover-
24 age with the State Accident Insurance Fund Corporation or an insurer authorized under ORS
25 chapter 731 to transact workers’ compensation insurance in this state.

26 “(5) ‘Child’ means a child of an injured worker, including:

27 “(a) A posthumous child;

28 “(b) A child legally adopted before the injury;

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

30 “(d) A child born out of wedlock;

31 “(e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker’s family
32 and substantially dependent upon the worker for support; and

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

35 “(6) ‘Claim’ means a written request for compensation from a subject worker or someone on the
36 worker’s behalf, or any compensable injury of which a subject employer has notice or knowledge.

37 “(7)(a) A ‘compensable injury’ is an accidental injury, or accidental injury to prosthetic appli-
38 ances, arising out of and in the course of employment requiring medical services or resulting in
39 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-
40 dental means, if it is established by medical evidence supported by objective findings, subject to the
41 following limitations:

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

44 “(B) If an otherwise compensable injury combines at any time with a preexisting condition to
45 cause or prolong disability or a need for treatment, the combined condition is compensable only if,

1 so long as and to the extent that the otherwise compensable injury is the major contributing cause
2 of the disability of the combined condition or the major contributing cause of the need for treatment
3 of the combined condition.

4 “(b) ‘Compensable injury’ does not include:

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

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

9 “(C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
10 the evidence the injured worker’s consumption of alcoholic beverages or cannabis or the unlawful
11 consumption of any controlled substance, unless the employer permitted, encouraged or had actual
12 knowledge of such consumption.

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

16 “(d) A ‘nondisabling compensable injury’ is any injury that requires medical services only.

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

20 “(9) ‘Department’ means the Department of Consumer and Business Services.

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

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

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

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

27 “(d) A sibling or stepsibling of a worker or the sibling’s or stepsibling’s spouse or domestic
28 partner; and

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

31 “(11) ‘Director’ means the Director of the Department of Consumer and Business Services.

32 “(12)(a) [*‘Doctor’ or ‘physician’*] **‘Doctor,’ ‘physician,’ ‘nurse practitioner’ or ‘physician as-**
33 **sociate’** means a person duly licensed to practice one or more of the healing arts in any country
34 or in any state, territory or possession of the United States within the limits of the license of the
35 licensee.

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

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

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

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

4 “(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a
5 similarly licensed surgeon in any country or in any state, territory or possession of the
6 United States;

7 “(iv) A nurse practitioner licensed under ORS 678.375 to 678.390 or a similarly licensed
8 nurse practitioner in any country or in any state, territory or possession of the United
9 States; or

10 “(v) A physician associate licensed by the Oregon Medical Board in accordance with ORS
11 677.505 to 677.525 or a similarly licensed physician associate in any country or in any state,
12 territory or possession of the United States; or

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

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

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

22 “[(C) For a cumulative total of 180 days from the first visit on the initial claim, a physician asso-
23 ciate licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly
24 licensed physician associate in any country or in any state, territory or possession of the United
25 States.]

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

29 “(d) ‘Consulting physician’ means a doctor or physician who examines a worker or the worker’s
30 medical record to advise the attending physician [*or nurse practitioner authorized to provide*
31 *compensable medical services under ORS 656.245*] regarding treatment of a worker’s compensable
32 injury.

33 “(13)(a) ‘Employer’ means any person, including receiver, administrator, executor or trustee, and
34 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
35 rations or political subdivisions, that contracts to pay a remuneration for the services of any
36 worker.

37 “(b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client
38 of a temporary service provider is not the employer of temporary workers provided by the temporary
39 service provider.

40 “(c) As used in paragraph (b) of this subsection, ‘temporary service provider’ has the meaning
41 given that term in ORS 656.849.

42 “(d) For the purposes of this chapter, ‘subject employer’ means an employer that is subject to
43 this chapter as provided in ORS 656.023.

44 “(14) ‘Insurer’ means the State Accident Insurance Fund Corporation or an insurer authorized
45 under ORS chapter 731 to transact workers’ compensation insurance in this state or an assigned

1 claims agent selected by the director under ORS 656.054.

2 “(15) ‘Consumer and Business Services Fund’ means the fund created by ORS 705.145.

3 “(16) ‘Incapacitated’ means an individual is physically or mentally unable to earn a livelihood.

4 “(17) ‘Medically stationary’ means that no further material improvement would reasonably be
5 expected from medical treatment or the passage of time.

6 “(18) ‘Noncomplying employer’ means a subject employer that has failed to comply with ORS
7 656.017.

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

12 “(20) ‘Palliative care’ means medical service rendered to reduce or moderate temporarily the
13 intensity of an otherwise stable medical condition, but does not include those medical services ren-
14 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

15 “(21) ‘Party’ means a claimant for compensation, the employer of the injured worker at the time
16 of injury and the insurer, if any, of the employer.

17 “(22) ‘Payroll’ means a record of wages payable to workers for their services and includes
18 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
19 similar advantage received from the employer. However, ‘payroll’ does not include overtime pay,
20 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
21 to reward workers for safe working practices. Bonus pay is limited to payments that are not antic-
22 ipated under the contract of employment and that are paid at the sole discretion of the employer.
23 The exclusion from payroll of bonus payments to reward workers for safe working practices is only
24 for the purpose of calculations based on payroll to determine premium for workers’ compensation
25 insurance, and does not affect any other calculation or determination based on payroll for the pur-
26 poses of this chapter.

27 “(23) ‘Person’ includes a partnership, joint venture, association, limited liability company and
28 corporation.

29 “(24)(a) ‘Preexisting condition’ means, for all industrial injury claims, any injury, disease, con-
30 genital abnormality, personality disorder or similar condition that contributes to disability or need
31 for treatment, provided that:

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

35 “(B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes
36 the initial injury;

37 “(ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the
38 new medical condition; or

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

41 “(b) ‘Preexisting condition’ means, for all occupational disease claims, any injury, disease, con-
42 genital abnormality, personality disorder or similar condition that contributes to disability or need
43 for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim
44 for worsening in such claims pursuant to ORS 656.273 or 656.278.

45 “(c) For the purposes of industrial injury claims, a condition does not contribute to disability

1 or need for treatment if the condition merely renders the worker more susceptible to the injury.

2 “(25) ‘Self-insured employer’ means an employer or group of employers certified under ORS
3 656.430 as meeting the qualifications set out by ORS 656.407.

4 “(26) ‘State Accident Insurance Fund Corporation’ and ‘corporation’ mean the State Accident
5 Insurance Fund Corporation created under ORS 656.752.

6 “(27) ‘Wages’ means the money rate at which the service rendered is recompensed under the
7 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
8 housing, lodging or similar advantage received from the employer, and includes the amount of tips
9 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
10 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
11 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
12 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
13 which any worker shall be carried upon the payroll of the employer for the purpose of determining
14 the premium of the employer.

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

21 “(b) For the purpose of determining entitlement to temporary disability benefits or permanent
22 total disability benefits under this chapter, ‘worker’ does not include a person who has withdrawn
23 from the workforce during the period for which such benefits are sought.

24 “(c) For the purposes of this chapter, ‘subject worker’ means a worker who is subject to this
25 chapter as provided in ORS 656.027.

26 “(29) ‘Independent contractor’ has the meaning given that term in ORS 670.600.

27 “**SECTION 45.** ORS 656.214 is amended to read:

28 “656.214. (1) As used in this section:

29 “(a) ‘Impairment’ means the loss of use or function of a body part or system due to the
30 compensable industrial injury or occupational disease determined in accordance with the standards
31 provided under ORS 656.726, expressed as a percentage of the whole person.

32 “(b) ‘Loss’ includes permanent and complete or partial loss of use.

33 “(c) ‘Permanent partial disability’ means:

34 “(A) Permanent impairment resulting from the compensable industrial injury or occupational
35 disease; or

36 “(B) Permanent impairment and work disability resulting from the compensable industrial injury
37 or occupational disease.

38 “(d) ‘Regular work’ means the job the worker held at injury.

39 “(e) ‘Work disability’ means impairment modified by age, education and adaptability to perform
40 a given job.

41 “(2) When permanent partial disability results from a compensable injury or occupational dis-
42 ease, benefits shall be awarded as follows:

43 “(a) If the worker has been released to regular work by the attending physician [*or nurse prac-*
44 *titioner authorized to provide compensable medical services under ORS 656.245*] or has returned to
45 regular work [*at the job held at the time of injury*], the award shall be for impairment only. Impair-

1 ment shall be determined in accordance with the standards provided by the Director of the Depart-
2 ment of Consumer and Business Services pursuant to ORS 656.726 (4). Impairment benefits are
3 determined by multiplying the impairment value times 100 times the average weekly wage as defined
4 by ORS 656.005.

5 “(b) If the worker has not been released to regular work by the attending physician [*or nurse*
6 *practitioner authorized to provide compensable medical services under ORS 656.245*] or has not re-
7 turned to regular work [*at the job held at the time of injury*], the award shall be for impairment and
8 work disability. Work disability shall be determined in accordance with the standards provided by
9 the director pursuant to ORS 656.726 (4). Impairment shall be determined as provided in paragraph
10 (a) of this subsection. Work disability benefits shall be determined by multiplying the impairment
11 value, as modified by the factors of age, education and adaptability to perform a given job, times
12 150 times the worker’s weekly wage for the job at injury as calculated under ORS 656.210 (2). The
13 factor for the worker’s weekly wage used for the determination of the work disability may be no
14 more than 133 percent or no less than 50 percent of the average weekly wage as defined in ORS
15 656.005.

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

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

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

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

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

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

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

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

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

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

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

45 “(k) For the loss of a first finger, eight percent; of a second finger, seven percent; of a third

1 finger, three percent; of a fourth finger, two percent.

2 “(4) The loss of one phalange of a thumb, including the adjacent epiphyseal region of the
3 proximal phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange
4 of a finger, including the adjacent epiphyseal region of the middle phalange, is considered equal to
5 the loss of one-half of a finger. The loss of two phalanges of a finger, including the adjacent
6 epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of 75 percent
7 of a finger. The loss of more than one phalange of a thumb, excluding the epiphyseal region of the
8 proximal phalange, is considered equal to the loss of an entire thumb. The loss of more than two
9 phalanges of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is con-
10 sidered equal to the loss of an entire finger. A proportionate loss of use may be allowed for an un-
11 injured finger or thumb where there has been a loss of effective opposition.

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

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

18 “**SECTION 46.** ORS 656.245 is amended to read:

19 “656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall
20 cause to be provided medical services for conditions caused in material part by the injury for such
21 period as the nature of the injury or the process of the recovery requires, subject to the limitations
22 in ORS 656.225, including such medical services as may be required after a determination of per-
23 manent disability. In addition, for consequential and combined conditions described in ORS 656.005
24 (7), the insurer or the self-insured employer shall cause to be provided only those medical services
25 directed to medical conditions caused in major part by the injury.

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

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

33 “(A) Services provided to a worker who has been determined to be permanently and totally
34 disabled.

35 “(B) Prescription medications.

36 “(C) Services necessary to administer prescription medication or monitor the administration of
37 prescription medication.

38 “(D) Prosthetic devices, braces and supports.

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

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

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

43 “(H) Services that are necessary to diagnose the worker’s condition.

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

45 “(J) With the approval of the insurer or self-insured employer, palliative care that the worker’s

1 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
2 the worker to continue current employment or a vocational training program. If the insurer or
3 self-insured employer does not approve, the attending physician or the worker may request approval
4 from the Director of the Department of Consumer and Business Services for such treatment. The
5 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
6 (3) to aid in the review of such treatment. The decision of the director is subject to review under
7 ORS 656.704.

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

12 “(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
13 of symptoms of the worker’s condition.

14 “(d) When the medically stationary date in a disabling claim is established by the insurer or
15 self-insured employer and is not based on the findings of the attending physician, the insurer or
16 self-insured employer is responsible for reimbursement to affected medical service providers for
17 otherwise compensable services rendered until the insurer or self-insured employer provides written
18 notice to the attending physician of the worker’s medically stationary status.

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

26 “(2)(a) The worker may choose an attending [*doctor, physician or nurse practitioner*] **physician**
27 within the State of Oregon. The worker may choose the initial attending physician [*or nurse practi-*
28 *tioner*] and may subsequently change attending physician [*or nurse practitioner*] two times without
29 approval from the director. If the worker thereafter selects another attending physician [*or nurse*
30 *practitioner*], the insurer or self-insured employer may require the director’s approval of the se-
31 lection. The decision of the director is subject to review under ORS 656.704. The worker also may
32 choose an attending doctor or physician in another country or in any state or territory or possession
33 of the United States with the prior approval of the insurer or self-insured employer.

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

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

41 “(B) A medical service provider who is not an attending physician cannot authorize the payment
42 of temporary disability compensation. However, an emergency room physician who is not authorized
43 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
44 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
45 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-

1 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

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

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

10 “[*(i) May provide compensable medical services for 180 days from the date of the first visit on the*
11 *initial claim;*]

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

14 “[*(iii) When an injured worker treating with a nurse practitioner or physician associate authorized*
15 *to provide compensable services under this section becomes medically stationary within the 180-day*
16 *period in which the nurse practitioner or physician associate is authorized to treat the injured worker,*
17 *shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS*
18 *656.005 for the purpose of making findings regarding the worker’s impairment for the purpose of*
19 *evaluating the worker’s disability. If a worker returns to the nurse practitioner or physician associate*
20 *after initial claim closure for evaluation of a possible worsening of the worker’s condition, the nurse*
21 *practitioner or physician associate shall refer the worker to an attending physician and the insurer*
22 *shall compensate the nurse practitioner or physician associate for the examination performed.*]

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

28 “(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the
29 insurer of an employer contracts with a managed care organization certified pursuant to ORS
30 656.260 for medical services required by this chapter to be provided to injured workers:

31 “(a) Those workers who are subject to the contract shall receive medical services in the manner
32 prescribed in the contract. Workers subject to the contract include those who are receiving medical
33 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
34 jury or medically stationary status, on or after the effective date of the contract. If the managed
35 care organization determines that the change in provider would be medically detrimental to the
36 worker, the worker shall not become subject to the contract until the worker is found to be med-
37 ically stationary, the worker changes physicians [*or nurse practitioners*], or the managed care or-
38 ganization determines that the change in provider is no longer medically detrimental, whichever
39 event first occurs. A worker becomes subject to the contract upon the worker’s receipt of actual
40 notice of the worker’s enrollment in the managed care organization, or upon the third day after the
41 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
42 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
43 worker may continue to treat with the attending physician [*or nurse practitioner*] authorized to
44 provide compensable medical services under this section under an expired or terminated managed
45 care organization contract if the **attending** physician [*or nurse practitioner*] agrees to comply with

1 the rules, terms and conditions regarding services performed under any subsequent managed care
2 organization contract to which the worker is subject. A worker shall not be subject to a contract
3 if the worker's primary residence is more than 100 miles outside the managed care organization's
4 certified geographical area. Each such contract must comply with the certification standards pro-
5 vided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that
6 is compensable from a medical service provider who is not a member of the managed care organ-
7 ization. Insurers or self-insured employers who contract with a managed care organization for med-
8 ical services shall give notice to the workers of eligible medical service providers and such other
9 information regarding the contract and manner of receiving medical services as the director may
10 prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying
11 employer is considered to be subject to a contract between the State Accident Insurance Fund
12 Corporation as a processing agent or the assigned claims agent and a managed care organization.

13 “(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-
14 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
15 vices from the managed care organization.

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

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

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

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

37 “(A) Maintains the worker's medical records;

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

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

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

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

45 “[i)] (A) Provide medical treatment to the worker if the treatment is determined to be medically

1 appropriate according to the service utilization review process of the managed care organization;
2 and

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

5 “[*B*] *The managed care organization may also authorize the nurse practitioner or physician as-*
6 *sociate to provide medical services and authorize temporary disability payments beyond the periods*
7 *established in subsection (2)(b)(D) of this section.*]

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

11 “**SECTION 47.** ORS 656.250 is amended to read:

12 “656.250. A physical therapist [*shall*] **may** not provide compensable services to injured workers
13 governed by this chapter except as allowed by a governing managed care organization contract or
14 as authorized by the worker’s attending physician [*or nurse practitioner authorized to provide*
15 *compensable medical services under ORS 656.245*].

16 “**SECTION 48.** ORS 656.252 is amended to read:

17 “656.252. (1) In order to ensure the prompt and correct reporting and payment of compensation
18 in compensable injuries, the Director of the Department of Consumer and Business Services shall
19 make rules governing audits of medical service bills and reports by attending and consulting physi-
20 cians and other personnel of all medical information relevant to the determination of a claim to the
21 injured worker’s representative, the worker’s employer, the employer’s insurer and the Department
22 of Consumer and Business Services. Such rules shall include, but not necessarily be limited to:

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

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

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

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

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

36 “(2) The attending physician [*or nurse practitioner authorized to provide compensable medical*
37 *services under ORS 656.245*] shall do the following:

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

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

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

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

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

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

14 “(5) Whenever an injured worker changes attending [*physicians or nurse practitioners authorized*
15 *to provide compensable medical services under ORS 656.245*] **physician**, the newly selected attending
16 physician [*or nurse practitioner*] shall so notify the responsible insurer or self-insured employer not
17 later than five days after the date of the change or the date of first treatment. Every attending
18 physician [*or nurse practitioner authorized to provide compensable medical services under ORS*
19 *656.245*] who refers a worker to a consulting physician promptly shall notify the responsible insurer
20 or self-insured employer of the referral.

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

24 “**SECTION 49.** ORS 656.262 is amended to read:

25 “656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
26 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
27 claims as required in this chapter.

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

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

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

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

36 “(C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
37 therefor.

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

39 “(E) Any other details the insurer may require.

40 “(b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
41 for any penalty the insurer is required to pay under subsection (11) of this section because of such
42 failure. As used in this subsection, ‘health insurance’ has the meaning for that term provided in ORS
43 731.162.

44 “(4)(a) The first installment of temporary disability compensation shall be paid no later than the
45 14th day after the subject employer has notice or knowledge of the claim and of the worker’s disa-

1 bility, if the attending physician [*or nurse practitioner authorized to provide compensable medical*
2 *services under ORS 656.245*] authorizes the payment of temporary disability compensation. There-
3 after, temporary disability compensation shall be paid at least once each two weeks, except where
4 the Director of the Department of Consumer and Business Services determines that payment in in-
5 stallments should be made at some other interval. The director may by rule convert monthly benefit
6 schedules to weekly or other periodic schedules.

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

11 “(c) Notwithstanding any other provision of this chapter, when the holder of a public office is
12 injured in the course and scope of that public office, full official salary paid to the holder of that
13 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
14 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, ‘public
15 office’ has the meaning for that term provided in ORS 260.005.

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

22 “(e) If a worker fails to appear at an appointment with the worker’s attending physician [*or*
23 *nurse practitioner authorized to provide compensable medical services under ORS 656.245*], the insurer
24 or self-insured employer shall notify the worker by certified mail that temporary disability benefits
25 may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails
26 to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment
27 of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled
28 appointment.

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

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

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

42 “(i) During periods in which there is a denial under the jurisdiction of the Workers’ Compen-
43 sation Board that affects the worker’s ability to obtain authorization of temporary disability;

44 “(ii) During periods in which there is a dispute over the identity of, or treatment by, an at-
45 tending physician [*or nurse practitioner*] that affects the worker’s ability to obtain authorization of

1 temporary disability; or

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

3 “(h) The worker’s disability may be authorized only by [*a person described*] **an attending phy-**
4 **sician as defined** in ORS 656.005 (12)(b)(B), or **a person described in ORS 656.245**, for the period
5 of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend
6 payment of temporary disability benefits to the worker at the expiration of the period until tempo-
7 rary disability is reauthorized by [*an*] **the** attending physician [*or nurse practitioner authorized to*
8 *provide compensable medical services under ORS 656.245*].

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

14 “(j)(A) The insurer or self-insured employer may not end temporary disability benefits until
15 written notice has been mailed or delivered to the worker and the worker’s attorney, if the worker
16 is represented. The notice must state the reason that temporary disability benefits are no longer due
17 and payable.

18 “(B) The worker’s attending physician [*or nurse practitioner*] may retroactively authorize tem-
19 porary disability for up to 45 days prior to the date of the notice.

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

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

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

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

44 “(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
45 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of

1 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
2 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
3 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
4 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
5 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
6 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
7 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
8 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
9 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
10 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
11 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
12 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
13 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
14 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
15 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
16 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
17 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
18 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
19 payable from the date any such benefits were terminated under the denial. Except as provided in
20 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
21 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
22 a copy of the notice of acceptance.

23 “(b) The notice of acceptance shall:

24 “(A) Specify what conditions are compensable.

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

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

29 “(D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
30 chapter 659A.

31 “(E) Inform the claimant of assistance available to employers and workers from the Reemploy-
32 ment Assistance Program under ORS 656.622.

33 “(F) Be modified by the insurer or self-insured employer from time to time as medical or other
34 information changes a previously issued notice of acceptance.

35 “(c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
36 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
37 the insurer or self-insured employer from later denying the combined or consequential condition if
38 the otherwise compensable injury ceases to be the major contributing cause of the combined or
39 consequential condition.

40 “(d) An injured worker who believes that a condition has been incorrectly omitted from a notice
41 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
42 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
43 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
44 revise the notice or to make other written clarification in response. A worker who fails to comply
45 with the communication requirements of this paragraph or ORS 656.267 may not allege at any

1 hearing or other proceeding on the claim a de facto denial of a condition based on information in
2 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
3 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

4 “(7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
5 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be
6 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
7 or self-insured employer receives written notice of such claims. A worker who fails to comply with
8 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
9 any hearing or other proceeding on the claim a de facto denial of a condition based on information
10 in the notice of acceptance from the insurer or self-insured employer.

11 “(b) Once a worker’s claim has been accepted, the insurer or self-insured employer must issue
12 a written denial to the worker when the accepted injury is no longer the major contributing cause
13 of the worker’s combined condition before the claim may be closed.

14 “(c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
15 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
16 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
17 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
18 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
19 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
20 garding that condition.

21 “(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
22 ceptance or denial to the noncomplying employer.

23 “(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record
24 with the Director of the Department of Consumer and Business Services denies a claim for com-
25 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
26 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the
27 claimant. The insurer shall issue a copy of the notice of denial to the employer. The insurer shall
28 notify the director of the denial in the manner the director prescribes by rule. The worker may re-
29 quest a hearing pursuant to ORS 656.319.

30 “(10) Merely paying or providing compensation shall not be considered acceptance of a claim
31 or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver
32 of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a
33 notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review
34 of such an order or notice of closure, shall not preclude an insurer or self-insured employer from
35 subsequently contesting the compensability of the condition rated therein, unless the condition has
36 been formally accepted.

37 “(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
38 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
39 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the
40 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
41 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable
42 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court
43 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-
44 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and
45 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed

1 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under
2 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the
3 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this
4 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-
5 ment and payment of the additional amount and attorney fees described in this subsection. The
6 action of the director and the review of the action taken by the director shall be subject to review
7 under ORS 656.704.

8 “(b) When the director does not have exclusive jurisdiction over proceedings regarding the as-
9 sessment and payment of the additional amount and attorney fees described in this subsection, the
10 provisions of this subsection shall apply in the other proceeding.

11 “(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the
12 insurer or self-insured employer has failed to make the payment in accordance with the requirements
13 specified in the disputed claim settlement, the claimant or the claimant’s attorney shall clearly no-
14 tify the insurer or self-insured employer in writing that the payment is past due. If the required
15 payment is not made within five business days after receipt of the notice by the insurer or self-
16 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
17 adopted by the director by rule.

18 “(b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney
19 fees authorized under this subsection. The matrix shall provide for penalties based on a percentage
20 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of
21 the settlement proceeds allocated to the claimant’s attorney as an attorney fee.

22 “(13) The insurer may authorize an employer to pay compensation to injured workers and shall
23 reimburse employers for compensation so paid.

24 “(14)(a) Injured workers have the duty to cooperate and assist the insurer or self-insured em-
25 ployer in the investigation of claims for compensation. Injured workers shall submit to and shall
26 fully cooperate with personal and telephonic interviews and other formal or informal information
27 gathering techniques. Injured workers who are represented by an attorney shall have the right to
28 have the attorney present during any personal or telephonic interview or deposition. If the injured
29 worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a
30 reasonable attorney fee based upon an hourly rate for actual time spent during the personal or
31 telephonic interview or deposition. After consultation with the Board of Governors of the Oregon
32 State Bar, the Workers’ Compensation Board shall adopt rules for the establishment, assessment and
33 enforcement of an hourly attorney fee rate specified in this subsection.

34 “(b) If the attorney is not willing or available to participate in an interview at a time reasonably
35 chosen by the insurer or self-insured employer within 14 days of the request for interview and the
36 insurer or self-insured employer has cause to believe that the attorney’s unwillingness or unavail-
37 ability is unreasonable and is preventing the worker from complying within 14 days of the request
38 for interview, the insurer or self-insured employer shall notify the director. If the director deter-
39 mines that the attorney’s unwillingness or unavailability is unreasonable, the director shall assess
40 a civil penalty against the attorney of not more than \$1,000.

41 “(15) If the director finds that a worker fails to reasonably cooperate with an investigation in-
42 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the
43 claim for a worsened condition, the director shall suspend all or part of the payment of compen-
44 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after
45 the notice, the insurer or self-insured employer may deny the claim because of the worker’s failure

1 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim
2 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the
3 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the
4 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291
5 that the worker fully and completely cooperated with the investigation, that the worker failed to
6 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-
7 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-
8 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain
9 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-
10 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order
11 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or
12 self-insured employer to accept or deny the claim.

13 “(16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for
14 hearing for a claim for compensation involving more than one potentially responsible employer or
15 insurer may specify what is required of an injured worker to reasonably cooperate with the inves-
16 tigation of the claim as required by subsection (14) of this section.

17 “**SECTION 50.** ORS 656.268 is amended to read:

18 “656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible
19 and as near as possible to a condition of self support and maintenance as an able-bodied worker.
20 The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director
21 of the Department of Consumer and Business Services, and determine the extent of the worker's
22 permanent disability, provided the worker is not enrolled and actively engaged in training according
23 to rules adopted by the director pursuant to ORS 656.340 and 656.726, when one of the following
24 conditions is met:

25 “(a) The worker has become medically stationary and there is sufficient information to deter-
26 mine permanent disability. Notwithstanding any other provision of this chapter, a physician [*or*
27 *nurse practitioner*] may not retroactively determine a worker to be medically stationary more than
28 60 days prior to the date of the determination except in the case of claims that are subject to sub-
29 section (13) of this section. An insurer or self-insured employer must mail or deliver written notice
30 to a worker and to the worker's attorney, if the worker is represented, within seven days following
31 receipt of information that the worker is medically stationary.

32 “(b) The accepted injury is no longer the major contributing cause of the worker's combined or
33 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
34 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
35 quential condition or conditions, and there is sufficient information to determine permanent disabili-
36 ty, the likely permanent disability that would have been due to the current accepted condition shall
37 be estimated.

38 “(c) Without the approval of the attending physician [*or nurse practitioner authorized to provide*
39 *compensable medical services under ORS 656.245*], the worker fails to seek medical treatment for a
40 period of 30 days or the worker fails to attend a closing examination, unless the worker
41 affirmatively establishes that such failure is attributable to reasons beyond the worker's control.

42 “(d) An insurer or self-insured employer finds that a worker who has been receiving permanent
43 total disability benefits has materially improved and is capable of regularly performing work at a
44 gainful and suitable occupation.

45 “(2) If the worker is enrolled and actively engaged in training according to rules adopted pur-

1 suant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately
2 reduced by any sums earned during the training.

3 “(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors
4 shall be furnished to the worker, if requested by the worker.

5 “(4) Temporary total disability benefits shall continue until whichever of the following events
6 first occurs:

7 “(a) The worker returns to regular or modified employment;

8 “(b) The attending physician [*or nurse practitioner who has authorized temporary disability ben-*
9 *efits for the worker under ORS 656.245*] advises the worker and documents in writing that the worker
10 is released to return to regular employment;

11 “(c) The attending physician [*or nurse practitioner who has authorized temporary disability ben-*
12 *efits for the worker under ORS 656.245*] advises the worker and documents in writing that the worker
13 is released to return to modified employment, such employment is offered in writing to the worker
14 and the worker fails to begin such employment. However, an offer of modified employment may be
15 refused by the worker without the termination of temporary total disability benefits if the offer:

16 “(A) Requires a commute that is beyond the physical capacity of the worker according to the
17 worker’s attending physician [*or the nurse practitioner who may authorize temporary disability under*
18 *ORS 656.245*];

19 “(B) Is at a work site more than 50 miles one way from where the worker was injured unless
20 the site is less than 50 miles from the worker’s residence or the intent of the parties at the time
21 of hire or as established by the pattern of employment prior to the injury was that the employer had
22 multiple or mobile work sites and the worker could be assigned to any such site;

23 “(C) Is not with the employer at injury;

24 “(D) Is not at a work site of the employer at injury;

25 “(E) Is not consistent with the existing written shift change policy or is not consistent with
26 common practice of the employer at injury or aggravation; or

27 “(F) Is not consistent with an existing shift change provision of an applicable collective bar-
28 gaining agreement;

29 “(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
30 or terminated under ORS 656.262 (4) or other provisions of this chapter; or

31 “(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician
32 [*or nurse practitioner who has authorized temporary disability benefits under ORS 656.245*] for a home
33 care worker or a personal support worker who has been made a subject worker pursuant to ORS
34 656.039 advises the home care worker or personal support worker and documents in writing that the
35 home care worker or personal support worker is released to return to modified employment, appro-
36 priate modified employment is offered in writing by the Home Care Commission or a designee of the
37 commission to the home care worker or personal support worker for any client of the Department
38 of Human Services who employs a home care worker or personal support worker and the worker
39 fails to begin the employment.

40 “(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker’s
41 disability in closure of the claim shall be pursuant to the standards prescribed by the director.

42 “(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the
43 worker and to the worker’s attorney if the worker is represented. The insurer or self-insured em-
44 ployer shall notify the director of the closure in the manner the director prescribes by rule. If the
45 worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer

1 shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the
2 worker's last known address and may mail copies of the notice of closure to any known or potential
3 beneficiaries to the estate of the deceased worker.

4 "(c) The notice of closure must inform:

5 "(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dis-
6 satisfied with the terms of the notice of closure;

7 "(B) The worker of:

8 "(i) The amount of any further compensation, including permanent disability compensation to
9 be awarded;

10 "(ii) The duration of temporary total or temporary partial disability compensation;

11 "(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the no-
12 tice of closure under paragraph (b) of this subsection to request reconsideration by the director
13 under this section within 60 days of the date of the notice of closure;

14 "(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under par-
15 agraph (b) of this subsection to request reconsideration by the director under this section within one
16 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
17 of this subsection;

18 "(v) The right of the insurer or self-insured employer to request reconsideration by the director
19 under this section within seven days of the date of the notice of closure;

20 "(vi) The aggravation rights; and

21 "(vii) Any other information as the director may require; and

22 "(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204
23 and 656.208.

24 "(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may
25 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
26 self-insured employer shall issue a notice of closure if the requirements of this section have been
27 met or a notice of refusal to close if the requirements of this section have not been met. A notice
28 of refusal to close shall advise the worker of:

29 "(A) The decision not to close;

30 "(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the
31 date of the notice of refusal to close;

32 "(C) The right to be represented by an attorney; and

33 "(D) Any other information as the director may require.

34 "(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the
35 notice of closure, the objecting party first must request reconsideration by the director under this
36 section. A worker's request for reconsideration must be made within 60 days of the date of the no-
37 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for
38 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under
39 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.
40 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not
41 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within
42 one year of the date the notice of closure was mailed to the estate of the worker under paragraph
43 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be
44 based only on disagreement with the findings used to rate impairment and must be made within
45 seven days of the date of the notice of closure.

1 “(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant
2 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing
3 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close
4 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid
5 to the worker in an amount equal to 25 percent of all compensation determined to be then due the
6 claimant.

7 “(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the di-
8 rector orders an increase by 25 percent or more of the amount of compensation to be paid to the
9 worker for permanent disability and the worker is found upon reconsideration to be at least 20
10 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured em-
11 ployer and paid to the worker in an amount equal to 25 percent of all compensation determined to
12 be then due the claimant. If the increase in compensation results from information that the insurer
13 or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have
14 known at the time of claim closure, from new information obtained through a medical arbiter ex-
15 amination or from a determination order issued by the director that addresses the extent of the
16 worker’s permanent disability that is not based on the standards adopted pursuant to ORS 656.726
17 (4)(f), the penalty shall not be assessed.

18 “(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
19 held on each notice of closure. At the reconsideration proceeding:

20 “(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
21 worker about the worker’s condition at the time of claim closure, shall become part of the recon-
22 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
23 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
24 cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the
25 deposition for the Department of Consumer and Business Services and one copy of the transcript
26 of the deposition for each party shall be paid by the insurer or self-insured employer. The recon-
27 sideration proceeding may not be postponed to receive a deposition taken under this subparagraph.
28 A deposition taken in accordance with this subparagraph may be received as evidence at a hearing
29 even if the deposition is not prepared in time for use in the reconsideration proceeding.

30 “(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured em-
31 ployer may correct information in the record that is erroneous and may submit any medical evidence
32 that should have been but was not submitted by the attending physician [*or nurse practitioner au-*
33 *thorized to provide compensable medical services under ORS 656.245*] at the time of claim closure.

34 “(C) If the director determines that a claim was not closed in accordance with subsection (1)
35 of this section, the director may rescind the closure.

36 “(b) If necessary, the director may require additional medical or other information with respect
37 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

38 “(c) In any reconsideration proceeding under this section in which the worker was represented
39 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
40 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
41 pensation awarded to the worker.

42 “(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall
43 be completed within 18 working days from the date the reconsideration proceeding begins, and shall
44 be performed by a special evaluation appellate unit within the department. The deadline of 18
45 working days may be postponed by an additional 60 calendar days if within the 18 working days the

1 department mails notice of review by a medical arbiter. If an order on reconsideration has not been
2 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within
3 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was
4 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-
5 section, or within such additional time as provided in subsection (8) of this section when reconsi-
6 deration is postponed further because the worker has failed to cooperate in the medical arbiter
7 examination, reconsideration shall be deemed denied and any further proceedings shall occur as
8 though an order on reconsideration affirming the notice of closure was mailed on the date the order
9 was due to issue.

10 “(e) The period for completing the reconsideration proceeding described in paragraph (d) of this
11 subsection begins upon receipt by the director of a worker’s or a beneficiary’s request for recon-
12 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
13 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the
14 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
15 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
16 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
17 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
18 ation proceeding, including the right to proceed with the reconsideration if the initiating party
19 withdraws the request for reconsideration.

20 “(f) Any medical arbiter report may be received as evidence at a hearing even if the report is
21 not prepared in time for use in the reconsideration proceeding.

22 “(g) If any party objects to the reconsideration order, the party may request a hearing under
23 ORS 656.283 within 30 days from the date of the reconsideration order.

24 “(7)(a) The director may delay the reconsideration proceeding and toll the reconsideration
25 timeline established under subsection (6) of this section for up to 45 calendar days if:

26 “(A) A request for reconsideration of a notice of closure has been made to the director within
27 60 days of the date of the notice of closure;

28 “(B) The parties are actively engaged in settlement negotiations that include issues in dispute
29 at reconsideration;

30 “(C) The parties agree to the delay; and

31 “(D) Both parties notify the director before the 18th working day after the reconsideration
32 proceeding has begun that they request a delay under this subsection.

33 “(b) A delay of the reconsideration proceeding granted by the director under this subsection
34 expires:

35 “(A) If a party requests the director to resume the reconsideration proceeding before the expi-
36 ration of the delay period;

37 “(B) If the parties reach a settlement and the director receives a copy of the approved settle-
38 ment documents before the expiration of the delay period; or

39 “(C) On the next calendar day following the expiration of the delay period authorized by the
40 director.

41 “(c) Upon expiration of a delay granted under this subsection, the timeline for the completion
42 of the reconsideration proceeding shall resume as if the delay had never been granted.

43 “(d) Compensation due the worker shall continue to be paid during the period of delay author-
44 ized under this subsection.

45 “(e) The director may authorize only one delay period for each reconsideration proceeding.

1 “(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement
2 with the impairment used in rating of the worker’s disability, the director shall refer the claim to
3 a medical arbiter appointed by the director.

4 “(b) If the director determines that insufficient medical information is available to determine
5 disability, the director may appoint, and refer the claim to, a medical arbiter.

6 “(c) At the request of either of the parties, the director shall appoint a panel of as many as three
7 medical arbiters in accordance with criteria that the director sets by rule.

8 “(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians
9 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected
10 in consultation with the Oregon Medical Board, **the Oregon State Board of Nursing** and the
11 committee referred to in ORS 656.790.

12 “(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform
13 such tests as may be reasonable and necessary to establish the worker’s impairment.

14 “(B) If the director determines that the worker failed to attend the examination without good
15 cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall
16 postpone the reconsideration proceedings for up to 60 days from the date of the determination that
17 the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this
18 or any prior opening of the claim until such time as the worker attends and cooperates with the
19 examination or the request for reconsideration is withdrawn. Any additional evidence regarding
20 good cause must be submitted prior to the conclusion of the 60-day postponement period.

21 “(C) At the conclusion of the 60-day postponement period, if the worker has not attended and
22 cooperated with a medical arbiter examination or established good cause, the worker may not attend
23 a medical arbiter examination for this claim closure. The reconsideration record must be closed, and
24 the director shall issue an order on reconsideration based upon the existing record.

25 “(D) All disability benefits suspended under this subsection, including all disability benefits
26 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers’ Com-
27 pensation Board or upon court review, are not due and payable to the worker.

28 “(f) The insurer or self-insured employer shall pay the costs of examination and review by the
29 medical arbiter or panel of medical arbiters.

30 “(g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the
31 director for reconsideration of the notice of closure.

32 “(h) After reconsideration, no subsequent medical evidence of the worker’s impairment is ad-
33 missible before the director, the Workers’ Compensation Board or the courts for purposes of making
34 findings of impairment on the claim closure.

35 “(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement
36 with the impairment used in rating the worker’s disability, and the director determines that the
37 worker is not medically stationary at the time of the reconsideration or that the closure was not
38 made pursuant to this section, the director is not required to appoint a medical arbiter before
39 completing the reconsideration proceeding.

40 “(B) If the worker’s condition has substantially changed since the notice of closure, upon the
41 consent of all the parties to the claim, the director shall postpone the proceeding until the worker’s
42 condition is appropriate for claim closure under subsection (1) of this section.

43 “(9) No hearing shall be held on any issue that was not raised and preserved before the director
44 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
45 resolved at hearing.

1 “(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
2 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
3 any permanent disability payments due for work disability under the closure shall be suspended, and
4 the worker shall receive temporary disability compensation and any permanent disability payments
5 due for impairment while the worker is enrolled and actively engaged in the training. When the
6 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
7 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
8 if the worker’s accepted injury is no longer the major contributing cause of the worker’s combined
9 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
10 duration of temporary total or temporary partial disability compensation. Permanent disability
11 compensation shall be redetermined for work disability only. If the worker has returned to work or
12 the worker’s attending physician has released the worker to return to regular or modified employ-
13 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
14 be appealed only in the same manner as are other notices of closure under this section.

15 “(11) If the attending physician [*or nurse practitioner authorized to provide compensable medical*
16 *services under ORS 656.245*] has approved the worker’s return to work and there is a labor dispute
17 in progress at the place of employment, the worker may refuse to return to that employment without
18 loss of reemployment rights or any vocational assistance provided by this chapter.

19 “(12) Any notice of closure made under this section may include necessary adjustments in com-
20 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
21 bility payments prematurely made, crediting temporary disability payments against current or future
22 permanent or temporary disability awards or payments and requiring the payment of temporary
23 disability payments which were payable but not paid.

24 “(13) An insurer or self-insured employer may take a credit or offset of previously paid workers’
25 compensation benefits or payments against any further workers’ compensation benefits or payments
26 due a worker from that insurer or self-insured employer when the worker admits to having obtained
27 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
28 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
29 fits or payments obtained through fraud by a worker may not be included in any data used for
30 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-
31 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the
32 director.

33 “(14)(a) An insurer or self-insured employer may offset any compensation payable to the worker
34 to recover an overpayment from a claim with the same insurer or self-insured employer. When
35 overpayments are recovered from temporary disability or permanent total disability benefits, the
36 amount recovered from each payment shall not exceed 25 percent of the payment, without prior
37 authorization from the worker.

38 “(b) An insurer or self-insured employer may suspend and offset any compensation payable to
39 the beneficiary of the worker, and recover an overpayment of permanent total disability benefits
40 caused by the failure of the worker’s beneficiaries to notify the insurer or self-insured employer
41 about the death of the worker.

42 “(15) Conditions that are direct medical sequelae to the original accepted condition shall be in-
43 cluded in rating permanent disability of the claim unless they have been specifically denied.

44 “(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured em-
45 ployer may not recover an overpayment from a worker’s permanent partial disability compensation

1 for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total
2 compensation awarded to the worker.

3 “(b) An insurer or self-insured employer may not declare an overpayment of any compensation
4 that was paid more than two years prior to the date of the declaration.

5 “**SECTION 51.** ORS 656.325 is amended to read:

6 “656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if
7 requested by the Director of the Department of Consumer and Business Services, the insurer or
8 self-insured employer, to submit to a medical examination at a time reasonably convenient for the
9 worker as may be provided by the rules of the director. No more than three independent medical
10 examinations may be requested except after notification to and authorization by the director. If the
11 worker refuses to submit to any such examination, or obstructs the same, the rights of the worker
12 to compensation shall be suspended with the consent of the director until the examination has taken
13 place, and no compensation shall be payable during or for account of such period. The provisions
14 of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

15 “(b) When a worker is requested by the director, the insurer or self-insured employer to attend
16 an independent medical examination, the examination must be conducted by a physician selected
17 from a list of qualified physicians established by the director under ORS 656.328.

18 “(c) The director shall adopt rules applicable to independent medical examinations conducted
19 pursuant to paragraph (a) of this subsection that:

20 “(A) Provide a worker the opportunity to request review by the director of the reasonableness
21 of the location selected for an independent medical examination. Upon receipt of the request for
22 review, the director shall conduct an expedited review of the location selected for the independent
23 medical examination and issue an order on the reasonableness of the location of the examination.
24 The director shall determine if there is substantial evidence for the objection to the location for the
25 independent medical examination based on a conclusion that the required travel is medically
26 contraindicated or other good cause establishing that the required travel is unreasonable. The de-
27 terminations of the director about the location of independent medical examinations are not subject
28 to review.

29 “(B) Impose a monetary penalty against a worker who fails to attend an independent medical
30 examination without prior notification or without justification for not attending the examination. A
31 penalty imposed under this subparagraph may be imposed only on a worker who is not receiving
32 temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may
33 offset any future compensation payable to the worker to recover any penalty imposed under this
34 subparagraph from a claim with the same insurer or self-insured employer. When a penalty is re-
35 covered from temporary disability or permanent total disability benefits, the amount recovered from
36 each payment may not exceed 25 percent of the benefit payment without prior authorization from
37 the worker.

38 “(C) Impose a sanction against a medical service provider that unreasonably fails to provide in
39 a timely manner diagnostic records required for an independent medical examination.

40 “(d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for
41 an independent medical examination is unreasonable, the insurer or self-insured employer shall ac-
42 cept or deny the claim within 90 days after the employer has notice or knowledge of the claim.

43 “(e) If the worker has made a timely request for a hearing on a denial of compensability as re-
44 quired by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pur-
45 suant to paragraph (a) of this subsection and the worker’s attending physician [*or nurse practitioner*

1 *authorized to provide compensable medical services under ORS 656.245*] does not concur with the re-
2 port or reports, the worker may request an examination to be conducted by a physician selected by
3 the director from the list described in ORS 656.328. The cost of the examination and the examination
4 report shall be paid by the insurer or self-insured employer.

5 “(f) The insurer or self-insured employer shall pay the costs of the medical examination and re-
6 lated services which are reasonably necessary to allow the worker to submit to any examination
7 requested under this section. As used in this paragraph, ‘related services’ includes, but is not limited
8 to, child care, travel, meals, lodging and an amount equivalent to the worker’s net lost wages for
9 the period during which the worker is absent if the worker does not receive benefits pursuant to
10 ORS 656.210 (4) during the period of absence. A claim for ‘related services’ described in this para-
11 graph shall be made in the manner prescribed by the director.

12 “(g) A worker who objects to the location of an independent medical examination must request
13 review by the director under paragraph (c)(A) of this subsection within six business days of the date
14 the notice of the independent medical examination was mailed.

15 “(2) For any period of time during which any worker commits insanitary or injurious practices
16 which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical
17 or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a
18 program of physical rehabilitation, the right of the worker to compensation shall be suspended with
19 the consent of the director and no payment shall be made for such period. The period during which
20 such worker would otherwise be entitled to compensation may be reduced with the consent of the
21 director to such an extent as the disability has been increased by such refusal.

22 “(3) A worker who has received an award for permanent total or permanent partial disability
23 should be encouraged to make a reasonable effort to reduce the disability; and the award shall be
24 subject to periodic examination and adjustment in conformity with ORS 656.268.

25 “(4) When the employer of an injured worker, or the employer’s insurer determines that the in-
26 jured worker has failed to follow medical advice from the attending physician [*or nurse practitioner*
27 *authorized to provide compensable medical services under ORS 656.245*] or has failed to participate
28 in or complete physical restoration or vocational rehabilitation programs prescribed for the worker
29 pursuant to this chapter, the employer or insurer may petition the director for reduction of any
30 benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director
31 finds that the worker has failed to accept treatment as provided in this subsection, the director may
32 reduce any benefits awarded the worker by such amount as the director considers appropriate.

33 “(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer
34 shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such
35 amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning em-
36 ployment prior to claim determination and the worker’s attending physician [*or nurse practitioner*
37 *authorized to provide compensable medical services under ORS 656.245*], after being notified by the
38 employer of the specific duties to be performed by the injured worker, agrees that the injured
39 worker is capable of performing the employment offered.

40 “(b) If the worker has been terminated for violation of work rules or other disciplinary reasons,
41 the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence
42 payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner authorized to*
43 *provide compensable medical services under ORS 656.245*] approves employment in a modified job that
44 would have been offered to the worker if the worker had remained employed, provided that the
45 employer has a written policy of offering modified work to injured workers.

1 “(c) If the worker is a person present in the United States in violation of federal immigration
2 laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and com-
3 mence payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner au-*
4 *thorized to provide compensable medical services under ORS 656.245*] approves employment in a
5 modified job whether or not such a job is available.

6 “(6) Any party may request a hearing on any dispute under this section pursuant to ORS
7 656.283.

8 “**SECTION 52.** ORS 656.340 is amended to read:

9 “656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be
10 provided to an injured worker who is eligible for assistance in returning to work.

11 “(b) For this purpose the insurer or self-insured employer shall contact a worker with a claim
12 for a disabling compensable injury or claim for aggravation for evaluation of the worker’s eligibility
13 for vocational assistance within five days of:

14 “(A) Having knowledge of the worker’s likely eligibility for vocational assistance, from a medical
15 or investigation report, notification from the worker, or otherwise; or

16 “(B) The time the worker is medically stationary, if the worker has not returned to or been re-
17 leased for the worker’s regular employment or has not returned to other suitable employment with
18 the employer at the time of injury or aggravation and the worker is not receiving vocational as-
19 sistance.

20 “(c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new
21 information that would change the eligibility determination.

22 “(2) Contact under subsection (1) of this section shall include informing the worker about re-
23 employment rights, the responsibility of the worker to request reemployment, and wage subsidy and
24 job site modification assistance and the provisions of the preferred worker program pursuant to
25 rules adopted by the Director of the Department of Consumer and Business Services.

26 “(3) Within five days after notification that the attending physician [*or nurse practitioner au-*
27 *thorized to provide compensable medical services under ORS 656.245*] has released a worker to return
28 to work, the insurer or self-insured employer shall inform the worker about the opportunity to seek
29 reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the
30 employer of the worker’s reemployment rights, wage subsidy and the job site modification assistance
31 and the provisions of the preferred worker program.

32 “(4) As soon as possible, and not more than 30 days after the contact required by subsection (1)
33 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-
34 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-
35 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the
36 worker’s eligibility for vocational assistance. If the insurer or self-insured employer decides that the
37 worker is not eligible, the worker may apply to the director for review of the decision as provided
38 in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection
39 (1)(b)(B) of this section, or because the worker’s eligibility has fully and finally expired under stan-
40 dards prescribed by the director, may not be found eligible thereafter unless that eligibility deter-
41 mination is rejected by the director under subsection (16) of this section or the worker’s condition
42 worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to
43 vocational assistance benefits when possible eligibility for such benefits arises from a worsening of
44 the worker’s condition that occurs after the expiration of the worker’s aggravation rights under ORS
45 656.273.

1 “(5) The objectives of vocational assistance are to return the worker to employment which is
2 as close as possible to the worker’s regular employment at a wage as close as possible to the weekly
3 wage currently being paid for employment which was the worker’s regular employment even though
4 the wage available following employment may be less than the wage prescribed by subsection (6)
5 of this section. As used in this subsection and subsection (6) of this section, ‘regular employment’
6 means the employment the worker held at the time of the injury or the claim for aggravation under
7 ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a
8 worker not employed at the time of the aggravation, the employment the worker held on the last
9 day of work prior to the aggravation.

10 “(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to
11 the previous employment or to any other available and suitable employment with the employer at
12 the time of injury or aggravation, and the worker has a substantial handicap to employment.

13 “(b) As used in this subsection:

14 “(A) A ‘substantial handicap to employment’ exists when the worker, because of the injury or
15 aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed
16 in suitable employment.

17 “(B) ‘Suitable employment’ means:

18 “(i) Employment of the kind for which the worker has the necessary physical capacity, knowl-
19 edge, skills and abilities;

20 “(ii) Employment that is located where the worker customarily worked or is within reasonable
21 commuting distance of the worker’s residence; and

22 “(iii) Employment that produces a weekly wage within 20 percent of that currently being paid
23 for employment that was the worker’s regular employment as defined in subsection (5) of this sec-
24 tion. The director shall adopt rules providing methods of calculating the weekly wage currently be-
25 ing paid for the worker’s regular employment for use in determining eligibility and for providing
26 assistance to eligible workers. If the worker’s regular employment was seasonal or temporary, the
27 worker’s wage shall be averaged based on a combination of the worker’s earned income and any
28 unemployment insurance payments. Only earned income evidenced by verifiable documentation such
29 as federal or state tax returns shall be used in the calculation. Earned income does not include
30 fringe benefits or reimbursement of the worker’s employment expenses.

31 “(7) Vocational evaluation, help in directly obtaining employment and training shall be available
32 under conditions prescribed by the director. The director may establish other conditions for pro-
33 viding vocational assistance, including those relating to the worker’s availability for assistance,
34 participation in previous assistance programs connected with the same claim and the nature and
35 extent of assistance that may be provided. Such conditions shall give preference to direct employ-
36 ment assistance over training.

37 “(8) An insurer or self-insured employer may utilize its own staff or may engage any other in-
38 dividual certified by the director to perform the vocational evaluation required by subsection (4) of
39 this section.

40 “(9) The director shall adopt rules providing:

41 “(a) Standards for and methods of certifying individuals qualified by education, training and ex-
42 perience to provide vocational assistance to injured workers;

43 “(b) Standards for registration of vocational assistance providers;

44 “(c) Conditions and procedures under which the certification of an individual to provide voca-
45 tional assistance services or the registration of a vocational assistance provider may be suspended

1 or revoked for failure to maintain compliance with the certification or registration standards;

2 “(d) Standards for the nature and extent of services a worker may receive, for plans for return
3 to work and for determining when the worker has returned to work; and

4 “(e) Procedures, schedules and conditions relating to the payment for services performed by a
5 vocational assistance provider, that are based on payment for specific services performed and not
6 fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for
7 direct worker purchases and for all vocational assistance providers and shall be the same within
8 suitable geographic areas.

9 “(10) Insurers and self-insured employers shall maintain records and make reports to the direc-
10 tor of vocational assistance actions at times and in the manner as the director may prescribe. The
11 requirements prescribed shall be for the purpose of assisting the Department of Consumer and
12 Business Services in monitoring compliance with this section to insure that workers receive timely
13 and appropriate vocational assistance. The director shall minimize to the greatest extent possible
14 the number, extent and kinds of reports required. The director shall compile a list of organizations
15 or agencies registered to provide vocational assistance. A current list shall be distributed by the
16 director to all insurers and self-insured employers. The insurer shall send the list to each worker
17 with the notice of eligibility.

18 “(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or
19 self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the
20 worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational
21 assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-
22 insured employer shall notify the director and the director shall select a provider. Any change in
23 the choice of vocational assistance provider is subject to the approval of the director.

24 “(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive tempo-
25 rary disability compensation for a maximum of 16 months. The insurer or self-insured employer may
26 voluntarily extend the payment of temporary disability compensation to a maximum of 21 months.
27 The director may order the payment of temporary disability compensation for up to 21 months upon
28 good cause shown by the injured worker. The costs related to vocational assistance training pro-
29 grams may be paid for periods longer than 21 months, but in no event may temporary disability
30 benefits be paid for a period longer than 21 months.

31 “(13) As used in this section, ‘vocational assistance provider’ means a public or private organ-
32 ization or agency that provides vocational assistance to injured workers.

33 “(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the
34 same type or extent of assistance.

35 “(b) Training shall not be provided to an eligible worker solely because the worker cannot ob-
36 tain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this
37 section unless such training will enable the worker to find employment which will produce a wage
38 significantly closer to that prescribed in subsection (6) of this section.

39 “(c) Nothing in this section shall be interpreted to expand the availability of training under this
40 section.

41 “(15) A physical capacities evaluation shall be performed in conjunction with vocational assist-
42 ance or determination of eligibility for such assistance at the request of the insurer or self-insured
43 employer or worker. The request shall be made to the attending physician [*or nurse practitioner*
44 *authorized to provide compensable medical services under ORS 656.245*]. [*The attending physician or*
45 *nurse practitioner,*] Within 20 days of the request, **the attending physician** shall perform a physical

1 capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured
2 employer and the worker in writing that the injured worker is incapable of participating in a phys-
3 ical capacities evaluation.

4 “(16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers re-
5 quires a high degree of cooperation between all of the participants in the vocational assistance
6 process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility
7 for and extent of vocational assistance services should be resolved through nonadversarial proce-
8 dures to the greatest extent possible consistent with constitutional principles. The director shall
9 adopt by rule a procedure for resolving vocational assistance disputes in the manner provided in this
10 subsection.

11 “(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding
12 vocational assistance, the worker must apply to the director for administrative review of the matter.
13 Application for review must be made not later than the 60th day after the date the worker was
14 notified of the action. The director shall complete the review within a reasonable time.

15 “(c) If the worker’s dissatisfaction is resolved by agreement of the parties, the agreement shall
16 be reduced to writing, and the director and the parties shall review the agreement and either ap-
17 prove or disapprove it. The agreement is subject to reconsideration by the director under limitations
18 prescribed by the director, but is not subject to review by any other forum.

19 “(d) If the worker’s dissatisfaction is not resolved by agreement of the parties, the director shall
20 resolve the matter in a written order based on a record sufficient to permit review. The order is
21 subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the
22 date the order was issued. At the hearing, the order of the director shall be modified only if it:

23 “(A) Violates a statute or rule;

24 “(B) Exceeds the statutory authority of the agency;

25 “(C) Was made upon unlawful procedure; or

26 “(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

27 “(e) For purposes of this subsection, the term ‘parties’ does not include a noncomplying em-
28 ployer.

29 “**SECTION 53.** ORS 656.726 is amended to read:

30 “656.726. (1) The Workers’ Compensation Board in its name and the Director of the Department
31 of Consumer and Business Services in the director’s name as director may sue and be sued, and each
32 shall have a seal.

33 “(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges
34 in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction
35 under this chapter and providing such policy advice as the director may request, and providing such
36 other review functions as may be prescribed by law. To that end any of its members or assistants
37 authorized thereto by the members shall have power to:

38 “(a) Hold sessions at any place within the state.

39 “(b) Administer oaths.

40 “(c) Issue and serve by the board’s representatives, or by any sheriff, subpoenas for the attend-
41 ance of witnesses and the production of papers, contracts, books, accounts, documents and testimony
42 before any hearing under ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this
43 chapter.

44 “(d) Generally provide for the taking of testimony and for the recording of proceedings.

45 “(3) The board chairperson is hereby charged with the administration of and responsibility for

1 the Hearings Division.

2 “(4) The director hereby is charged with duties of administration, regulation and enforcement
3 of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter. To that end the
4 director may:

5 “(a) Make and declare all rules and issue orders which are reasonably required in the perform-
6 ance of the director’s duties. Unless otherwise specified by law, all reports, claims or other docu-
7 ments shall be deemed timely provided to the director or board if mailed by regular mail or
8 delivered within the time required by law. Notwithstanding any other provision of this chapter, the
9 director may adopt rules to allow for the electronic transmission and filing of reports, claims or
10 other documents required to be filed under this chapter and to require the electronic transmission
11 and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding
12 ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the
13 director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable
14 or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order,
15 subject to review under ORS 656.704. Such order shall not have precedential effect as to any other
16 situation.

17 “(b) Hold sessions at any place within the state.

18 “(c) Administer oaths.

19 “(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
20 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
21 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director
22 or the director’s representatives. The director may require the attendance and testimony of em-
23 ployers, their officers and representatives in any inquiry under this chapter, and the production by
24 employers of books, records, papers and documents without the payment or tender of witness fees
25 on account of such attendance.

26 “(e) Generally provide for the taking of testimony and for the recording of such proceedings.

27 “(f) Provide standards for the evaluation of disabilities. The following provisions apply to the
28 standards:

29 “(A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use
30 or function of a body part or system due to the compensable industrial injury or occupational dis-
31 ease. Permanent impairment is expressed as a percentage of the whole person. The impairment value
32 may not exceed 100 percent of the whole person.

33 “(B) Impairment is established by a preponderance of medical evidence based upon objective
34 findings.

35 “(C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment
36 as modified by the factors of age, education and adaptability to perform a given job.

37 “(D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that
38 the worker’s disability is not addressed by the standards adopted pursuant to this paragraph,
39 notwithstanding ORS 656.268, the director shall, in the order on reconsideration, determine the ex-
40 tent of permanent disability that addresses the worker’s impairment.

41 “(E) Notwithstanding any other provision of this section, only impairment benefits shall be
42 awarded under ORS 656.214 if the worker has been released to regular work by the attending phy-
43 sician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*]
44 or has returned to regular work at the job held at the time of injury.

45 “(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings

1 pursuant to ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter regarding
2 all matters other than those specifically allocated to the board or the Hearings Division.

3 “(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals
4 in which the director determines that the proceeding involves a matter that affects or could affect
5 the discharge of the director’s duties of administration, regulation and enforcement of ORS 654.001
6 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

7 “(5)(a) The board may make and declare all rules which are reasonably required in the per-
8 formance of its duties, including but not limited to rules of practice and procedure in connection
9 with hearing and review proceedings and exercising its authority under ORS 656.278. The board
10 shall adopt standards governing the format and timing of the evidence. The standards shall be uni-
11 formly followed by all Administrative Law Judges and practitioners. The rules may provide for in-
12 formal prehearing conferences in order to expedite claim adjudication, amicably dispose of
13 controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall
14 specify who may appear with parties at prehearing conferences and hearings.

15 “(b) Notwithstanding any other provision of this chapter, the board may adopt rules to allow for
16 the electronic transmission of filings, reports, notices and other documents required to be filed under
17 the board’s authority.

18 “(6) The director and the board chairperson may incur such expenses as they respectively de-
19 termine are reasonably necessary to perform their authorized functions.

20 “(7) The director, the board chairperson and the State Accident Insurance Fund Corporation
21 shall have the right, not subject to review, to contract for the exchange of, or payment for, such
22 services between them as will reduce the overall cost of administering this chapter.

23 “(8) The director shall have lien and enforcement powers regarding assessments to be paid by
24 subject employers in the same manner and to the same extent as is provided for lien and enforce-
25 ment of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

26 “(9) The director shall have the same powers regarding inspection of books, records and payrolls
27 of employers as are granted the corporation under ORS 656.758. The director may disclose infor-
28 mation obtained from such inspections to the Director of the Department of Revenue to the extent
29 the Director of the Department of Revenue requires such information to determine that a person
30 complies with the revenue and tax laws of this state and to the Director of the Employment De-
31 partment to the extent the Director of the Employment Department requires such information to
32 determine that a person complies with ORS chapter 657.

33 “(10) The director shall collect hours-worked data information in addition to total payroll for
34 workers engaged in various jobs in the construction industry classifications described in the job
35 classification portion of the Workers’ Compensation and Employers Liability Manual and the Oregon
36 Special Rules Section published by the National Council on Compensation Insurance. The informa-
37 tion shall be collected in the form and format necessary for the National Council on Compensation
38 Insurance to analyze premium equity.

39 “**SECTION 54.** ORS 656.797 is amended to read:

40 “656.797. On or after October 1, 2004, **prior to providing compensable medical services or**
41 **authorizing temporary disability benefits**, a nurse practitioner licensed under ORS 678.375 to
42 678.390[*prior to providing compensable medical services or authorizing temporary disability benefits*
43 *under ORS 656.245,*] **or a similarly licensed nurse practitioner in any country or in any state,**
44 **territory or possession of the United States** must certify in a form acceptable to the Director
45 of the Department of Consumer and Business Services that the nurse practitioner has reviewed the

1 materials developed under ORS 656.795.

2 “**SECTION 55.** ORS 659A.043 is amended to read:

3 “659A.043. (1) A worker who has sustained a compensable injury shall be reinstated by the
4 worker’s employer to the worker’s former position of employment upon demand for such rein-
5 statement, if the position exists and is available and the worker is not disabled from performing the
6 duties of such position. A worker’s former position is available even if that position has been filled
7 by a replacement while the injured worker was absent. If the former position is not available, the
8 worker shall be reinstated in any other existing position that is vacant and suitable. A certificate
9 by the attending physician, **as defined in ORS 656.005 (12)**, [or a nurse practitioner authorized to
10 provide compensable medical services under ORS 656.245] that the **attending** physician [or nurse
11 practitioner] approves the worker’s return to the worker’s regular employment or other suitable
12 employment shall be prima facie evidence that the worker is able to perform such duties.

13 “(2) Such right of reemployment shall be subject to the provisions for seniority rights and other
14 employment restrictions contained in a valid collective bargaining agreement between the employer
15 and a representative of the employer’s employees.

16 “(3) Notwithstanding subsection (1) of this section:

17 “(a) The right to reinstatement to the worker’s former position under this section terminates
18 when whichever of the following events first occurs:

19 “[A] A medical determination by the attending physician or, after an appeal of such determination
20 to a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656, has been made that the
21 worker cannot return to the former position of employment.]

22 “**(A) The worker cannot return to the former position of employment according to:**

23 “**(i) The medical determination of the attending physician; or**

24 “**(ii) Upon appeal of the attending physician’s determination, the determination of a
25 medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

26 “(B) The worker is eligible and participates in vocational assistance under ORS 656.340.

27 “(C) The worker accepts suitable employment with another employer after becoming medically
28 stationary.

29 “(D) The worker refuses a bona fide offer from the employer of light duty or modified employ-
30 ment that is suitable prior to becoming medically stationary.

31 “(E) Seven days elapse from the date that the worker is notified by the insurer or self-insured
32 employer by certified mail that the worker’s attending physician [or a nurse practitioner authorized
33 to provide compensable medical services under ORS 656.245] has released the worker for employment
34 unless the worker requests reinstatement within that time period.

35 “(F) Three years elapse from the date of injury.

36 “(b) The right to reinstatement under this section does not apply to:

37 “(A) A worker hired on a temporary basis as a replacement for an injured worker.

38 “(B) A seasonal worker employed to perform less than six months’ work in a calendar year.

39 “(C) A worker whose employment at the time of injury resulted from referral from a hiring hall
40 operating pursuant to a collective bargaining agreement.

41 “(D) A worker whose employer employs 20 or fewer workers at the time of the worker’s injury
42 and at the time of the worker’s demand for reinstatement.

43 “(4) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
44 section (3)(a)(D) of this section and who otherwise is entitled to family leave under ORS 659A.150
45 to 659A.186:

1 “(a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
2 refusing the offer of employment; and

3 “(b) Need not give additional written or oral notice to the employer that the employee is com-
4 mencing a period of family leave.

5 “(5) Any violation of this section is an unlawful employment practice.

6 “**SECTION 56.** ORS 659A.046 is amended to read:

7 “659A.046. (1) A worker who has sustained a compensable injury and is disabled from performing
8 the duties of the worker’s former regular employment shall, upon demand, be reemployed by the
9 worker’s employer at employment which is available and suitable.

10 “(2) A certificate of the worker’s attending physician, **as defined in ORS 656.005 (12)**, [*or a*
11 *nurse practitioner authorized to provide compensable medical services under ORS 656.245*] that the
12 worker is able to perform described types of work shall be prima facie evidence of such ability.

13 “(3) Notwithstanding subsection (1) of this section, the right to reemployment under this section
14 terminates when whichever of the following events first occurs:

15 “[*(a) The worker cannot return to reemployment at any position with the employer either by de-*
16 *termination of the attending physician or a nurse practitioner authorized to provide compensable med-*
17 *ical services under ORS 656.245 or upon appeal of that determination, by determination of a medical*
18 *arbiter or panel of medical arbiters pursuant to ORS chapter 656.*]

19 “**(a) The worker cannot return to reemployment at any position with the employer ac-**
20 **ording to:**

21 “**(A) The determination of the attending physician; or**

22 “**(B) Upon appeal of the attending physician’s determination, the determination of a**
23 **medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

24 “(b) The worker is eligible and participates in vocational assistance under ORS 656.340.

25 “(c) The worker accepts suitable employment with another employer after becoming medically
26 stationary.

27 “(d) The worker refuses a bona fide offer from the employer of light duty or modified employ-
28 ment that is suitable prior to becoming medically stationary.

29 “(e) Seven days elapse from the date that the worker is notified by the insurer or self-insured
30 employer by certified mail that the worker’s attending physician [*or a nurse practitioner authorized*
31 *to provide compensable medical services under ORS 656.245*] has released the worker for reemploy-
32 ment unless the worker requests reemployment within that time period.

33 “(f) Three years elapse from the date of injury.

34 “(4) Such right of reemployment shall be subject to the provisions for seniority rights and other
35 employment restrictions contained in a valid collective bargaining agreement between the employer
36 and a representative of the employer’s employees.

37 “(5) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
38 section (3)(d) of this section and who otherwise is entitled to family leave under ORS 659A.150 to
39 659A.186:

40 “(a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
41 refusing the offer of employment; and

42 “(b) Need not give additional written or oral notice to the employer that the employee is com-
43 mencing a period of family leave.

44 “(6) Any violation of this section is an unlawful employment practice.

45 “(7) This section applies only to employers who employ six or more persons.

1 “**SECTION 57.** ORS 659A.049 is amended to read:

2 “659A.049. The rights of reinstatement **and reemployment** afforded by ORS 659A.043 and
3 659A.046 shall not be forfeited if the worker refuses to return to the worker’s regular or other of-
4 fered employment without release to such employment by the worker’s attending physician **as de-**
5 **defined in ORS 656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical services*
6 *under ORS 656.245*].

7 “**SECTION 58.** ORS 659A.063 is amended to read:

8 “659A.063. (1) The State of Oregon shall cause group health benefits to continue in effect with
9 respect to that worker and any covered dependents or family members by timely payment of the
10 premium that includes the contribution due from the state under the applicable benefit plan, subject
11 to any premium contribution due from the worker that the worker paid before the occurrence of the
12 injury or illness. If the premium increases or decreases, the State of Oregon and worker contribu-
13 tions shall be adjusted to remain consistent with similarly situated active employees. The State of
14 Oregon shall continue the worker’s health benefits in effect until whichever of the following events
15 occurs first:

16 “(a) The worker’s attending physician **as defined in ORS 656.005 (12)** [*or a nurse practitioner*
17 *authorized to provide compensable medical services under ORS 656.245*] has determined the worker
18 to be medically stationary and a notice of closure has been entered;

19 “(b) The worker returns to work for the State of Oregon, after a period of continued coverage
20 under this section, and satisfies any probationary or minimum work requirement to be eligible for
21 group health benefits;

22 “(c) The worker takes full- or part-time employment with another employer that is comparable
23 in terms of the number of hours per week the worker was employed with the State of Oregon or the
24 worker retires;

25 “(d) Twelve months have elapsed since the date the State of Oregon received notice that the
26 worker filed a workers’ compensation claim pursuant to ORS chapter 656;

27 “(e) The claim is denied and the claimant fails to appeal within the time provided by ORS
28 656.319 or the Workers’ Compensation Board or a workers’ compensation hearings referee or a court
29 issues an order finding the claim is not compensable;

30 “(f) The worker does not pay the required premium or portion thereof in a timely manner in
31 accordance with the terms and conditions under this section;

32 “(g) The worker elects to discontinue coverage under this section and notifies the State of
33 Oregon in writing of this election;

34 “(h) The worker’s attending physician [*or a nurse practitioner authorized to provide compensable*
35 *medical services under ORS 656.245*] has released the worker to modified or regular work, the work
36 has been offered to the worker and the worker refuses to return to work; or

37 “(i) The worker has been terminated from employment for reasons unrelated to the workers’
38 compensation claim.

39 “(2) If the workers’ compensation claim of a worker for whom health benefits are provided pur-
40 suant to subsection (1) of this section is denied and the worker does not appeal or the worker ap-
41 peals and does not prevail, the State of Oregon may recover from the worker the amount of the
42 premiums plus interest at the rate authorized by ORS 82.010. The State of Oregon may recover the
43 payments through a payroll deduction not to exceed 10 percent of gross pay for each pay period.

44 “(3) The State of Oregon shall notify the worker of the provisions of ORS 659A.060 to 659A.069,
45 and of the remedies available for breaches of ORS 659A.060 to 659A.069, within a reasonable time

1 after the State of Oregon receives notice that the worker will be absent from work as a result of
2 an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter
3 656. The notice from the State of Oregon shall include the terms and conditions of the continuation
4 of health benefits and what events will terminate the coverage.

5 “(4) If the worker fails to make timely payment of any premium contribution owing, the State
6 of Oregon shall notify the worker of impending cancellation of the health benefits and provide the
7 worker with 30 days to pay the required premium prior to canceling the policy.

8 “(5) It is an unlawful employment practice for the State of Oregon to discriminate against a
9 worker, as defined in ORS 659A.060, by terminating the worker's group health benefits while that
10 worker is absent from the place of employment as a result of an injury or illness for which a
11 workers' compensation claim has been filed pursuant to ORS chapter 656, except as provided for in
12 this section.

13 “**SECTION 59.** ORS 657.170 is amended to read:

14 “657.170. (1) If the Director of the Employment Department finds that during the base year of
15 the individual any individual has been incapable of work during the greater part of any calendar
16 quarter, such base year shall be extended a calendar quarter. Except as provided in subsection (2)
17 of this section, no such extension of an individual's base year shall exceed four calendar quarters.

18 “(2) If the director finds that during and prior to the individual's base year the individual has
19 had a period of temporary total disability caused by illness or injury and has received compensation
20 under ORS chapter 656 for a period of temporary total disability during the greater part of any
21 calendar quarter, the individual's base year shall be extended as many calendar quarters as neces-
22 sary to establish a valid claim, up to a maximum of four calendar quarters prior to the quarter in
23 which the illness or injury occurred, if the individual:

24 “(a) Files a claim for benefits not later than the fourth calendar week of unemployment follow-
25 ing whichever is the latest of the following dates:

26 “(A) The date the individual is released to return to work by the attending physician[, *as defined*
27 *in ORS chapter 656, or a nurse practitioner authorized to provide compensable medical services under*
28 *ORS 656.245*] **as defined in ORS 656.005 (12)**; or

29 “(B) The date of mailing of a notice of claim closure pursuant to ORS chapter 656; and

30 “(b) Files such a claim within the three-year period immediately following the commencement
31 of such period of illness or injury.

32 “(3) Notwithstanding the provisions of this section, benefits payable as a result of the use of
33 wages paid in a calendar quarter prior to the individual's current base year shall not exceed one-
34 third of such wages less benefits paid previously as a result of the use of such wages in computing
35 a previous benefit determination.

36
37 **“CAPTIONS**

38
39 “**SECTION 60.** **The unit captions used in this 2026 Act are provided only for the conven-**
40 **ience of the reader and do not become part of the statutory law of this state or express any**
41 **legislative intent in the enactment of this 2026 Act.**

42
43 **“EFFECTIVE DATE**

44
45 “**SECTION 61.** **This 2026 Act being necessary for the immediate preservation of the public**

1 **peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect**
2 **on its passage.”**

3
