House Bill 4040

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

SUMMARY

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

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

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

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

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

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

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

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

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

Modifies the composition of the Medicaid Advisory Committee.

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

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

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

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

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

Requires the Legislative Policy and Research Director to develop and propose to the Legislative Policy and Research Committee an insurance coverage mandate impact statement policy. Directs the committee to perform due diligence in considering the proposal and authorizes the committee to modify the proposal if the committee so determines, and then to adopt the policy.

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

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

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

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

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

Includes nurse practitioners and physician associates in the definition of "attending physician" for purposes of the treatment of workers' compensable injuries.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

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

Relating to health care; creating new provisions; amending ORS 411.447, 414.074, 414.211, 414.572, 414.690, 414.773, 427.191, 442.615, 443.085, 443.446, 475A.325, 475A.338, 475A.372, 646A.693, 656.005, 656.214, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340, 656.726, 656.797, 657.170, 659A.043, 659A.046, 659A.049, 659A.063, 678.733, 679.025, 685.100, 685.102, 743B.456, 744.702, 750.055 and 750.333 and section 5, chapter 575, Oregon Laws 2015; repealing ORS 743A.310 and 743B.221; and declaring an emergency.

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

HOSPITALS

SECTION 1. ORS 442.615 is amended to read:

442.615. (1) As used in this section:

(a) "Financial assistance" includes:

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

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

(b) "Hospital" has the meaning given that term in ORS 442.612.

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

(a) Is uninsured;

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

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

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

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

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

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

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

(4) A patient may apply for financial assistance:

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

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

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

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

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

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

(b) If the hospital previously determined, incorrectly, that the patient did not qualify for finan-

cial assistance for the services based on information provided by the patient at the time of the incorrect determination, the hospital shall also pay the patient interest on the amount of financial assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such as legal expenses and fees, incurred by the patient in securing financial assistance; and

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

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

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

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

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

(a) The hospital has initiated collection activities, the hospital must suspend all collection activities; and

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

HOME HEALTH AND RESIDENTIAL CARE

SECTION 2. ORS 443.085 is amended to read:

443.085. **(1) Except as provided in subsection (2) of this section,** the Oregon Health Authority shall adopt rules to implement ORS 443.014 to 443.105 including, but not limited to:

[*(1)*] **(a)** The qualifications of professional and ancillary personnel in order to adequately furnish home health services;

[*(2)*] **(b)** Standards for the organization and quality of client care;

[*(3)*] **(c)** Procedures for maintaining records;

[*(4)*] **(d)** Provision for contractual arrangements for professional and ancillary health services; and

[*(5)*] **(e)** Complaint and inspection procedures.

(2) The authority may not require a home health agency to comply with the conditions of participation prescribed by the Centers for Medicare and Medicaid Services under 42 C.F.R. 484 unless the home health agency is certified by the Centers for Medicare and Medicaid Services.

SECTION 3. ORS 443.446 is amended to read:

443.446. (1) The Residential Care Quality Measurement Program is established in the Department of Human Services. Under the program, the department shall, no later than July 1 of each year, publish an annual report, based on data reported by each residential care facility under subsection (2) of this section. Excluding data that identifies a resident, the report must include data compilation, illustration and narratives to:

(a) Describe statewide patterns and trends that emerge from the data reported to the department under subsection (2) of this section and compliance data maintained by the department;

(b) Identify residential care facilities that substantially failed to report data as required by this section;

(c) Allow residential care facilities and the public to compare a residential care facility's performance on each quality metric, by demographics, geographic region, facility type and other categories the department believes may be useful to consumers and facilities;

(d) Show trends in performance on each of the quality metrics;

(e) Identify patterns of performance by geographic regions and other categories the department believes will be useful to consumers;

(f) Identify the number, severity and scope of regulatory violations by each geographic region; and

(g) Show average timelines for surveys and for investigations of abuse or regulatory noncompliance.

(2) Each residential care facility shall report, no later than January 31 of each year and in the form and manner prescribed by the Quality Measurement Council established under ORS 443.447, the quality metrics developed by the council under ORS 443.447.

(3) The department shall make available an annual report to each residential care facility that reports quality metrics under subsection (2) of this section using data compilation, illustration and narratives to allow the residential care facility to measure and compare its quality metrics over time.

(4)**(a)** The department shall make available to the public in a standard format and in plain language the data reported by each residential care facility, excluding information that identifies a resident.

(b) The department shall post on its website the information described in subsection (1)(c) of this section in an easily accessible manner that allows consumers and facilities to search for and compare a residential care facility's performance on each quality metric.

(5) The department shall, using moneys from the Quality Care Fund established under ORS 443.001:

(a) Develop online training modules to address the top two statewide issues identified by surveys or reviews of residential care facilities during the previous year; and

(b) Post and regularly update the data used to prepare the report described in subsection (1) of this section.

(6) The Quality Measurement Council, in consultation with the department, shall establish a uniform system for residential care facilities to report quality metrics as required by subsection (2) of this section. The system must:

(a) Allow for electronic reporting of data, to the greatest extent practicable; and

(b) Take into account and utilize existing data reporting systems used by residential care facilities.

(7)(a) Quality metric data reported to the department under this section may not be used as the basis for an enforcement action by the department nor may the data be disclosed to another agency for use in an enforcement or regulatory action.

(b) Quality metric data are not admissible as evidence in any civil action, including but not limited to judicial, administrative, arbitration or mediation proceedings.

(c) Quality metric data reported to the department are not subject to:

(A) Civil or administrative subpoena; or

(B) Discovery in connection with a civil action, including but not limited to judicial, administrative, arbitration or mediation proceedings.

(8) Subsection (7) of this section does not exempt a residential care facility from complying with state law or prohibit the department's use of quality metric data obtained from another source in the normal course of business or compliance activity.

SECTION 4. ORS 678.733 is amended to read:

678.733. (1) The Health Licensing Office may issue a residential care facility administrator license to an applicant who:

(a) Is at least 21 years of age;

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

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

(B) Passage of an approved high school equivalency test, including but not limited to the General Educational Development (GED) test; or

(C) Graduation from a post-secondary institution;

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

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

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

(e) Pays a licensure fee; and

(f) Passes an examination described in ORS 678.743.

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

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

SECTION 5. The amendments to ORS 678.733 by section 4 of this 2026 Act apply to applications for licensure under ORS 678.733 submitted to the Health Licensing Office on or after the effective date of this 2026 Act.

SECTION 6. (1) The amendments to ORS 678.733 by section 4 of this 2026 Act become operative on January 1, 2027.

(2) The Health Licensing Office make take any action before the operative date specified in subsection (1) of this section that is necessary to enable the office to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the office by the amendments to ORS 678.733 by section 4 of this 2026 Act.

MEDICAL ASSISTANCE

SECTION 7. ORS 411.447 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 8. ORS 414.074 is amended to read:

414.074. (1) As used in this section, "complex rehabilitation technology" means manual or power wheelchair systems, adaptive seating systems, alternative positioning systems, adaptive strollers, standing frames, gait trainers or specifically designated options or accessories that are:

(a) Classified as durable medical equipment; and

(b) Individually configured for a specific individual to meet the individual's unique medical, physical or functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment.

[*(2) The Oregon Health Authority or a coordinated care organization shall make a determination on a request for prior authorization for medical assistance coverage for the cost to repair complex rehabilitation technology within 72 hours after receiving the request.*]

(2) The Oregon Health Authority or a coordinated care organization may not require prior authorization for medical assistance coverage for the cost to repair complex rehabili-

tation technology if the cost is $1,500 or less.

(3)(a) The authority or a coordinated care organization may require prior authorization for medical assistance coverage for the cost to repair complex rehabilitation technology if the cost is greater than $1,500.

(b) If the authority or a coordinated care organization requires prior authorization under paragraph (a) of this subsection, the authority or the coordinated care organization shall approve or deny a prior authorization request made under this section within 72 hours after receiving the request.

SECTION 9. ORS 414.690 is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit **and provide meaningful opportunity for** testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

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

(A) The agenda for the meeting; and

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

(i) A drug or drug class review;

(ii) A technology review; and

(iii) Coverage guidance.

(b) Once the authority has posted an agenda under this subsection, the agenda may not be changed.

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

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

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

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

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

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

(A) Whether a service is cost-effective;

(B) Whether a service is recommended; or

(C) The value of a service.

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

[*(4)*] **(5)** In order to encourage effective and efficient medical evaluation and treatment, the

commission:

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

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

(c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, including drug therapies, in determining their relative importance using peer-reviewed medical literature.

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

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

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

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

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

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

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

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

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

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

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

SECTION 10. ORS 414.211 is amended to read:

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

(2) The committee shall be composed of:

(a) A physician licensed under ORS chapter 677;

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

(c) [*Two*] **Four** Medicaid recipients, [*one of whom shall be a*] **including one** person with a disability **and one person who qualifies for medical assistance based on modified adjusted gross**

income criteria;

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

(e) The Director of Human Services or designee;

(f) Health care providers;

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

(h) Members of the general public.

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

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

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

SECTION 11. The amendments to ORS 414.211 by section 10 of this 2026 Act become operative on July 10, 2027.

SECTION 12. Notwithstanding ORS 414.211, the Medicaid Advisory Committee shall be composed of:

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

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

SECTION 13. Section 12 of this 2026 Act is repealed on January 2, 2028.

SECTION 13a. ORS 414.773 is amended to read:

414.773. (1) A claim for reimbursement for a behavioral health service or a physical health service provided to a medical assistance recipient may not be denied by the Oregon Health Authority or a coordinated care organization on the basis that the behavioral health service and physical health service were provided on the same day or in the same facility, unless required by state or federal law.

(2) A coordinated care organization may not require prior authorization for specialty behavioral health services provided to a medical assistance recipient at a behavioral health home or a patient centered primary care home unless permitted to do so by the authority.

[*(3) A coordinated care organization must assign a member of the coordinated care organization to a primary care provider if the member has not selected a primary care provider by the 90th day after enrollment in medical assistance. The coordinated care organization shall provide notice of the assignment to the member and to the primary care provider.*]

[*(4) A member may select a different primary care provider at any time.*]

[*(5)*] **(3)** Subsection (1) of this section does not apply to coordinated care organizations' payments to providers using a value-based payment arrangement or other alternative payment methodology.

PARENT PROVIDERS

SECTION 14. ORS 427.191 is amended to read:

427.191. (1) As used in this section:

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

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

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

(A) Has a developmental or intellectual disability; or

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

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

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

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

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

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

(i) "Parent" includes a:

(A) Natural or adoptive parent of a child;

(B) Stepparent of a child; and

(C) Legal guardian of a child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Grocery shopping for the household;

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

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

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

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

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

(b) Must clearly state that the assignment is limited to decisions regarding the development and

implementation of the **client** child's individual support plan and does not limit the authority of the parent provider to make decisions for the client child with respect to health care, education or religious training.

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

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

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

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

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

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

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

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

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

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

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

(g) A requirement that parent providers who are employed as personal support workers are paid comparably to parent providers who are employed as direct support professionals;

(h) Procedures to ensure program integrity and prevent duplicate payment for the same service hours; and

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

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

(10) Annually, the department shall report to the interim committees of the Legislative Assembly related to human services or, if the Legislative Assembly is in session, to the committees of the

Legislative Assembly related to human services, in the manner provided in ORS 192.245, updates on the program described in this section, including:

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

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

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

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

DENTAL

SECTION 15. ORS 414.572 is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and other payment mechanisms described in subsection (6) of this section and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care

quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, behavioral health care, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members are provided:

(A) Assistance in navigating the health care delivery system;

(B) Assistance in accessing community and social support services and statewide resources;

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions or behavioral health conditions and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally and linguistically appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 413.022 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental subcontractor selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A behavioral health provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment

options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5)(a) The authority shall:

(A) Adopt by rule the requirements for a dental subcontractor that contracts with a coordinated care organization**, including requirements that oral health care consumers have a choice of providers and that dental subcontractors and coordinated care organizations may not prevent an oral health care provider from informing a consumer about the consumer's choice of providers**; and

(B) Incorporate the requirements adopted under this subsection into any contract entered into between the authority and a coordinated care organization under this section.

(b) The authority may not require a dental subcontractor that contracts with a coordinated care organization to produce any report or other information unless the requirement is:

(A) Established by state or federal statute, rule or regulation; or

(B) Included in a contract entered into between the authority and a coordinated care organization.

(6) In addition to global budgets, the authority may employ other payment mechanisms to reimburse coordinated care organizations for specified health services during limited periods of time if:

(a) Global budgets remain the primary means of reimbursing coordinated care organizations for care and services provided to the coordinated care organization's members;

(b) The other payment mechanisms are consistent with the legislative intent expressed in ORS 414.018 and the system design described in ORS 414.570 (1); and

(c) The payment mechanisms are employed only for health-related social needs services, such as housing supports, nutritional assistance and climate-related assistance, approved for the demonstration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.

SECTION 16. ORS 679.025 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 17. (1) The amendments to ORS 679.025 by section 16 of this 2026 Act become operative on January 1, 2027.

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

COMMERCIAL HEALTH INSURANCE

SECTION 18. Section 19 of this 2026 Act is added to and made a part of the Insurance Code.

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

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

SECTION 20. Section 19 of this 2026 Act applies to group or individual policies of casualty insurance or health insurance, including health benefit plans, that are issued, renewed or extended on or after the effective date of this 2026 Act.

SECTION 21. Sections 22, 24 and 25 of this 2026 Act are added to and made a part of the Insurance Code.

SECTION 22. As used in ORS 743B.456 and sections 24 and 25 of this 2026 Act:

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

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

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

SECTION 23. ORS 743B.456 is amended to read:

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

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

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

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

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

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

(4) Except as provided in this subsection, when a claim under a dental insurance plan is submitted to a dental insurer by a dental provider on behalf of a beneficiary, the dental insurer shall pay a clean claim or deny the claim not later than 45 days after the date on which the dental insurer receives the claim. If a dental insurer requires additional information before payment of a claim, not later than 45 days after the date on which the dental insurer receives the claim, the dental insurer shall notify the beneficiary and the dental provider in writing or electronically, and give the beneficiary and the dental provider an explanation of the additional information needed to process the claim. The dental insurer shall pay a clean claim or deny the claim not later than 45 days after the date on which the dental insurer receives the additional information.

(5) A contract between a dental insurer and a dental provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section or has the effect of relieving either party of its obligations under this section.

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

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

SECTION 24. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a dental provider.

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

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

(A) Requests the refund in writing or electronically on or before the last day of the period specified by the contract with the dental provider or 18 months after the date the payment was made, whichever is earlier; and

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

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

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

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

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

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

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

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

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

(5) A dental insurer may at any time request from a dental provider a refund of a payment previously made to satisfy a claim if:

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

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

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

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

SECTION 25. A dental provider that bills a dental insurer for covered services provided to an individual who is insured under a dental insurance plan shall be reimbursed by the insurer by a direct payment issued to the dental provider.

SECTION 26. Sections 22, 24 and 25 of this 2026 Act and the amendments to ORS 743B.456 by section 23 of this 2026 Act become operative on January 1, 2028.

SECTION 27. (1) As used in this section and section 28 of this 2026 Act, "insurance coverage mandate" means a proposed legislative measure that requires payment for certain services of health care providers or that requires an offering of health insurance coverage by an insurer or a health care service contractor as a component of an individual or group health insurance policy.

(2) The Legislative Policy and Research Director shall develop, as a pilot program, an insurance coverage mandate impact statement template. The template must solicit the information sought in section 28 of this 2026 Act and must take into consideration:

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

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

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

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

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

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

(a) The template methodology and review process;

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

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

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

(7) Following the presentations described in subsection (5) of this section and following or contemporaneously with the presentations described in subsection (6) of this section and taking into account provided feedback, the director shall propose to the Legislative Policy and Research Committee a policy that describes the objectives, content and form of an insurance coverage mandate impact statement and the procedures to be followed in the preparation of those statements. After conducting due deliberations in which the committee may make modifications to the policy, the committee shall adopt a policy on the preparation of insurance coverage mandate impact statements. The policy shall include guidance on when an insurance coverage mandate impact statement must be posted online on the Legislative Assembly website, relative to the location in the legislative process of the associated legislative measure.

(8) All agencies of state government, as defined in ORS 174.111, and the Oregon Health and Science University are directed to assist the director in the performance of the director's duties under this section and section 28 of this 2026 Act and, to the extent permitted by laws relating to confidentiality, to furnish information and advice that the director considers necessary to perform the director's duties.

SECTION 28. An insurance coverage mandate impact statement required to be developed under section 27 of this 2026 Act shall include but need not be limited to the following:

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

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

(3) Whether the proposed measure ensures more or less equitable access to treatment

or services by residents of this state;

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

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

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

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

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

(9) The extent to which a lack of the coverage in the proposed measure results in financial hardship to residents of this state; and

(10) The financial effects of the proposed measure based on an actuarial analysis conducted by the Department of Consumer and Business Services, including:

(a) The extent to which the proposed measure is expected to increase or decrease the cost of treatment or services and the utilization of treatment or services;

(b) The extent to which the treatment or services covered by the proposed measure are expected to substitute for more expensive treatment or services;

(c) The per member per month cost of the proposed measure to the Public Employees' Benefit Board, the Oregon Educators Benefit Board and enrollees in individual, small employer group and large employer group health insurance plans;

(d) The extent to which the coverage required by the proposed measure will cause an increase in premiums that will impose a financial hardship on residents of this state, particularly in rural areas or frontier areas, as designated by the Office of Rural Health; and

(e) The estimated impact of the proposed measure on the total cost of health care in this state.

SECTION 29. No later than September 15, 2027, the Legislative Policy and Research Director shall report to the Legislative Assembly in the manner provided under ORS 192.245 on recommendations for changes to improve upon the review of proposed insurance coverage mandates during regular or special sessions of the Legislative Assembly. The recommendations may include legislative proposals or explanations of the need for additional resources.

SECTION 30. ORS 743A.310 and 743B.221 are repealed.

SECTION 31. Section 5, chapter 575, Oregon Laws 2015, as amended by section 8, chapter 26, Oregon Laws 2016, section 19, chapter 489, Oregon Laws 2017, and section 15, chapter 37, Oregon Laws 2022, is amended to read:

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

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

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

SECTION 32. ORS 750.055 is amended to read:

750.055. (1) The following provisions apply to health care service contractors to the extent not

inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.138 and 705.139.

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

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

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

(e) ORS 734.014 to 734.440.

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

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

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

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

(j) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

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

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

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

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

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

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

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

(4) Any for-profit health care service contractor organized under the laws of any other state that

is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

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

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

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

SECTION 33. ORS 750.055, as amended by section 7, chapter 388, Oregon Laws 2025, is amended to read:

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

(a) ORS 705.137, 705.138 and 705.139.

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

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

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

(e) ORS 734.014 to 734.440.

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

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

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

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

(j) The following provisions of ORS chapter 744:

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

ers;

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

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

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

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

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

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

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

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

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

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

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

SECTION 34. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12, chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152, Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws 2024, section 22, chapter 70, Oregon Laws 2024, section 163, chapter 73, Oregon Laws 2024, sections 6 and 8, chapter 388, Oregon Laws 2025, section 6, chapter 536, Oregon Laws 2025, and section 19, chapter 539, Oregon Laws 2025, is amended to read:

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

(a) ORS 705.137, 705.138 and 705.139.

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

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not

including ORS 732.582, and ORS 732.650 to 732.689.

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

(e) ORS 734.014 to 734.440.

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

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

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

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

(j) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

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

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

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

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

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

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

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

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

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

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

to 734.710.

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

SECTION 35. ORS 750.333 is amended to read:

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

(a) ORS 705.137, 705.138 and 705.139.

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

(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.

(d) ORS 734.014 to 734.440.

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

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

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

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

(i) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

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

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

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

(2) For the purposes of this section:

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

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

(c) Contributions are premiums.

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

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

SECTION 36. ORS 750.333, as amended by section 10, chapter 388, Oregon Laws 2025, is

amended to read:

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

(a) ORS 705.137, 705.138 and 705.139.

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

(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.

(d) ORS 734.014 to 734.440.

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

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

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

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

(i) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

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

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

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

(2) For the purposes of this section:

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

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

(c) Contributions are premiums.

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

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

PHARMACY

SECTION 37. ORS 744.702 is amended to read:

744.702. (1) Subject to ORS 744.704, a person shall not transact business or purport or offer to

transact business as a third party administrator in this state unless the person holds a third party administrator license issued by the Director of the Department of Consumer and Business Services.

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

(a) Directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of this state or residents of another state from offices in this state, in connection with life insurance or health insurance coverage; or

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

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

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

SECTION 38. ORS 646A.693 is amended to read:

646A.693. (1) The Prescription Drug Affordability Board is established in the Department of Consumer and Business Services to protect residents of this state, state and local governments, commercial health plans, health care providers, pharmacies licensed in this state and other stakeholders within the health care system in this state from the high costs of prescription drugs.

(2) The board consists of eight members appointed by the Governor.

(3) The term of office of each member of the board is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) The appointment of each member of the board is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(5) A member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The members of the board must be residents of this state with expertise in health care economics and clinical medicine.

(7) A member of the board may not be an employee of, a board member of or a consultant to a manufacturer or a trade association of manufacturers.

(8) **The Governor shall select one of the members of the board as chairperson.** The board shall select one of its members [*as chairperson and another*] as vice chairperson[,]**. The chairperson and vice chairperson shall serve** for terms and with duties and powers necessary for the performance of the functions of the offices as the board determines.

(9) A majority of the members of the board constitutes a quorum for the transaction of business.

(10) The department shall appoint an executive director for the board, may employ consultants, investigators or other staff and shall provide staff support to the board to carry out its duties.

(11) The board shall meet at least once every six weeks at a time and place determined by the

chairperson. The chairperson may cancel or postpone a regular meeting if there is no prescription drug to review. The board may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(12)(a) The following actions by the board shall be open to the public in accordance with ORS 192.610 to 192.705:

(A) Any deliberation on whether to conduct an affordability review of a prescription drug under ORS 646A.694; and

(B) Any decision or deliberation toward a decision on any matter before the board except as provided in paragraph (b) of this subsection.

(b) The board may meet in executive session to discuss trade secret information.

(13) The board shall:

(a) Provide public notice of each board meeting at least two weeks in advance of the meeting;

(b) Make materials for each board meeting available to the public at least one week in advance of the meeting;

(c) Provide an opportunity for public comment at each open meeting of the board; and

(d) Provide the public with the opportunity to submit written comments on any pending decision of the board.

(14) The board may allow expert testimony at board meetings, including when the board meets in executive session.

(15)(a) A member of the board shall recuse the member from decisions related to a prescription drug if the member, or an immediate family member of the member, has received or could receive any of the following:

(A) A direct financial benefit of any amount deriving from the result or finding of a study, review or determination by or for the board; or

(B) A financial benefit from any person that owns, manufactures, or provides prescription drugs, services or items to be reviewed by the board that in the aggregate exceeds $5,000 per year.

(b) For the purposes of paragraph (a) of this subsection, a financial benefit includes honoraria, fees, stock, the value of the member's or immediate family member's stock holdings and any direct financial benefit deriving from the result or finding of a study, review or determination by or for the board.

(c) A conflict of interest shall be disclosed:

(A) By the board when hiring board staff;

(B) By the Governor when appointing members to the board; and

(C) By the board, when a member of the board is recused in any final decision resulting from a review of a prescription drug.

(d) A conflict of interest shall be disclosed at the earlier of:

(A) Prior to the first board meeting after the conflict is identified; or

(B) Within five days after the conflict is identified.

(e) A conflict of interest disclosed under this section shall be posted on the website of the board unless the chairperson of the board recuses the member from any final decision resulting from a review of a prescription drug.

(f) A posting under paragraph (e) of this subsection shall include the type, nature and magnitude of the conflict of interest of the member involved.

(16) Members of the board, staff and third parties that contract with the board may not accept any gift or donation of services or property that creates a potential conflict of interest or has the

appearance of biasing the work of the board.

(17)(a) The board may enter into a contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the board.

(b) Unless permission is granted by the board, a third party hired by the board may not release, publish or otherwise use any information to which the third party has access under its contract.

(18) In accordance with applicable provisions of ORS chapter 183, the board may adopt rules necessary for the administration of ORS 646A.680 to 646A.697.

SECTION 39. Nothing in the amendments to ORS 646A.693 by section 38 of this 2026 Act affects the term of office of any member of the Prescription Drug Affordability Board appointed prior to and serving on the effective date of this 2026 Act.

PSILOCYBIN

SECTION 40. ORS 475A.325 is amended to read:

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

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

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

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

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

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

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

[*(f)*] **(e)** [*Must*] Have passed an examination approved, administered or recognized by the authority; and

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

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

(4) The authority shall adopt rules that:

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

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

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

(d) Allow an applicant who has completed a psilocybin service facilitator training program in another state if the training program is approved by the regulatory body responsible for regulating psilocybin in that state and is approved by the authority. The authority may approve a training program described in this paragraph if the authority finds that the training program is substantially similar to those training programs in this state that are approved by the authority under ORS 475A.380.

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

(a) May not exceed, together with other fees collected under ORS 475A.210 to 475A.722, the cost

of administering ORS 475A.210 to 475A.722; and

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

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

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

SECTION 41. ORS 475A.338 is amended to read:

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

(A) The Occupational Therapy Licensing Board;

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

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

(D) The Oregon Board of Physical Therapy;

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

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

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

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

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

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

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

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

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

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

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

SECTION 42. ORS 475A.372 is amended to read:

475A.372. (1) As used in this section, "adverse behavioral reaction" and "adverse medical reaction" have the meanings given those terms by rule by the Oregon Health Authority.

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

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

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

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

(b) Compile and maintain the following information that pertains to the three-month period im-

mediately preceding a quarterly submission under subsection (4) of this section:

(A) The number of clients served;

(B) The number of individual administration sessions provided;

(C) The number of group administration sessions provided;

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

(E) The number and severity of:

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

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

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

(c) Compute, for the period described in paragraph (b) of this subsection, and maintain the following information:

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

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

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

(D) For doses of five milligrams or less of psilocybin analyte, the total average dose of psilocybin per client per administration session.

(3) Pursuant to rules adopted by the authority, a client may request that a psilocybin service center operator not submit to the authority information provided by the client as described in subsection (2) of this section.

(4) Subject to subsection (3) of this section, a psilocybin service center operator shall aggregate and submit, in a manner that protects the personally identifiable information of a client or individual from whom information is collected, to the authority on a quarterly basis the information described in subsection (2) of this section. The authority may exempt from the submission requirement information that the authority determines cannot be adequately deidentified.

(5) The authority shall submit the information received under subsection (4) of this section to the Oregon Health and Science University for the purpose of enabling the evaluation of outcomes of psilocybin services provided under ORS 475A.210 to 475A.722.

(6)(a) Except as otherwise required by law, the information collected, maintained and reported under this section is exempt from disclosure under ORS 192.311 to 192.478.

(b) Information collected, computed, maintained or reported under this section may not be sold.

(7) The authority may adopt rules to carry out this section. Rules adopted under this section may include rules to require a psilocybin service center operator to collect and submit to the authority information in addition to that described in subsection (2) of this section that, in the discretion of the authority, would be beneficial to understanding the outcomes of psilocybin services provided under ORS 475A.210 to 475A.722.

SECTION 43. (1) The amendments to ORS 475A.325, 475A.338 and 475A.372 by sections 40 to 42 of this 2026 Act become operative on January 1, 2027.

(2) The Oregon Health Authority, the Occupational Therapy Licensing Board and the Oregon Board of Physical Therapy may take any action before the operative date specified

in subsection (1) of this section that is necessary to enable the authority and the boards to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority and the boards by the amendments to ORS 475A.325, 475A.338 and 475A.372 by sections 40 to 42 of this 2026 Act.

NATUROPATHIC PHYSICIANS

SECTION 44. Sections 45 and 46 of this 2026 Act are added to and made a part of ORS chapter 685.

SECTION 45. A naturopathic physician may prescribe durable medical equipment.

SECTION 46. A naturopathic physician may cause a patient to be admitted to a hospital.

SECTION 47. ORS 685.100 is amended to read:

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

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

(a) A completed board renewal form containing any information required by the board to determine the applicant's eligibility for license renewal;

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

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

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

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

(5) A person holding an active license under this chapter may convert the license to inactive status by meeting the requirements set by rule of the board and paying any required fees. A person holding a license issued under this chapter who is at least [*70*] **60** years of age and retired from the practice of naturopathic medicine may convert the license to retired status by meeting the requirements set by rule of the board and paying any required fees.

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

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

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

(8) The board shall assess fees for:

(a) An initial license.

(b) Examination.

(c) Renewal of an active license.

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

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

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

(g) A duplicate license.

(h) A wall certificate.

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

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

SECTION 47a. ORS 685.102 is amended to read:

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

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

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

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

(3) Notwithstanding subsection (2) of this section, a person holding a license under this chapter may be exempted from the requirements of subsection (1) of this section upon application showing evidence satisfactory to the board that the applicant is or will be in the next calendar year at least [*70*] **60** years of age and is retired or will retire in the next calendar year from the practice of naturopathic medicine.

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

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

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

SECTION 48. (1) Sections 45 and 46 of this 2026 Act and the amendments to ORS 685.100

and 685.102 by sections 47 and 47a of this 2026 Act become operative on January 1, 2027.

(2) The Oregon Board of Naturopathic Medicine may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by sections 45 and 46 of this 2026 Act and the amendments to ORS 685.100 and 685.102 by sections 47 and 47a of this 2026 Act.

WORKERS' COMPENSATION RECLASSIFICATION OF PHYSICIAN ASSOCIATES AND NURSE PRACTITIONERS

SECTION 49. ORS 656.005 is amended to read:

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

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

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

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

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

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

(a) A posthumous child;

(b) A child legally adopted before the injury;

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

(d) A child born out of wedlock;

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

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

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

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

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

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

(b) "Compensable injury" does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A)**(i)** A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board**;**[*, or*]

(ii) A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board**;**[,]

(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry**;** [*or*]

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

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

(vi) A similarly licensed doctor in any country or in any state, territory or possession of the United States; **or**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

sponses to physical examinations that are not reproducible, measurable or observable.

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

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

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

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

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

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

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

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

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

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

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

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

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

(27) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips

reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

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

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

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

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

SECTION 50. ORS 656.005, as amended by section 22, chapter 78, Oregon Laws 2025, is amended to read:

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

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

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

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

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

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

(a) A posthumous child;

(b) A child legally adopted before the injury;

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

(d) A child born out of wedlock;

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

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

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

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

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

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

(b) "Compensable injury" does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A)**(i)** A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board**;**[*, or*]

(ii) A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board**;**[,]

(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry**;** [*or*]

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

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

(vi) A similarly licensed doctor in any country or in any state, territory or possession of the United States; **or**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 51. ORS 656.214 is amended to read:

656.214. (1) As used in this section:

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

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

(c) "Permanent partial disability" means:

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

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

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

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

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

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

by ORS 656.005.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) The loss of one phalange of a thumb, including the adjacent epiphyseal region of the proximal phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange of a finger,

including the adjacent epiphyseal region of the middle phalange, is considered equal to the loss of one-half of a finger. The loss of two phalanges of a finger, including the adjacent epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of 75 percent of a finger. The loss of more than one phalange of a thumb, excluding the epiphyseal region of the proximal phalange, is considered equal to the loss of an entire thumb. The loss of more than two phalanges of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of an entire finger. A proportionate loss of use may be allowed for an uninjured finger or thumb where there has been a loss of effective opposition.

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

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

SECTION 52. ORS 656.245 is amended to read:

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

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

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

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

(J) With the approval of the insurer or self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable the worker to continue current employment or a vocational training program. If the insurer or self-insured employer does not approve, the attending physician or the worker may request approval

from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such treatment. The decision of the director is subject to review under ORS 656.704.

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

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

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

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

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

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

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

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

(C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician

at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

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

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

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

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

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

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians [*or nurse practitioners*], or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician [*or nurse practitioner*] authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the **attending** physician [*or nurse practitioner*] agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's

certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured employer may require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization.

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

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

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

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

(A) Maintains the worker's medical records;

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

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

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

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

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

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

section].

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

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

SECTION 53. ORS 656.250 is amended to read:

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

SECTION 54. ORS 656.252 is amended to read:

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

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

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

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

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

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

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

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

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

(c) Advise the insurer or self-insured employer within five days of the date the injured worker is released to return to work. Under no circumstances shall the physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] notify the insurer or employer

of the worker's release to return to work without notifying the worker at the same time.

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

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

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

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

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

SECTION 55. ORS 656.262 is amended to read:

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

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

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

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

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

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

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

(E) Any other details the insurer may require.

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

(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim and of the worker's disability, if the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where

the Director of the Department of Consumer and Business Services determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

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

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

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

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

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

(g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] ceases to authorize temporary disability or for any period of time not authorized by the attending physician [*or nurse practitioner*]. No authorization of temporary disability compensation by the attending physician [*or nurse practitioner*] under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 45 days prior to its issuance.

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

(i) During periods in which there is a denial under the jurisdiction of the Workers' Compensation Board that affects the worker's ability to obtain authorization of temporary disability;

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

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

(h) The worker's disability may be authorized only by [*a person described*] **an attending physi-**

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

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

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

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

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

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

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

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

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-

tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

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

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

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

(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

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

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

(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

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

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of acceptance or denial to the noncomplying employer.

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

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

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be reasonable attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court shall consider the proportionate benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this

chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

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

(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

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

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

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

(b) If the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

(15) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the

claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim.

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

SECTION 56. ORS 656.268 is amended to read:

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

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

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

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

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

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors

shall be furnished to the worker, if requested by the worker.

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

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

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

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

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

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

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter; or

(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician [*or nurse practitioner who has authorized temporary disability benefits under ORS 656.245*] for a home care worker or a personal support worker who has been made a subject worker pursuant to ORS 656.039 advises the home care worker or personal support worker and documents in writing that the home care worker or personal support worker is released to return to modified employment, appropriate modified employment is offered in writing by the Home Care Commission or a designee of the commission to the home care worker or personal support worker for any client of the Department of Human Services who employs a home care worker or personal support worker and the worker fails to begin the employment.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director.

(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall notify the director of the closure in the manner the director prescribes by rule. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice of closure;

(B) The worker of:

(i) The amount of any further compensation, including permanent disability compensation to be awarded;

(ii) The duration of temporary total or temporary partial disability compensation;

(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within 60 days of the date of the notice of closure;

(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection;

(v) The right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of closure;

(vi) The aggravation rights; and

(vii) Any other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:

(A) The decision not to close;

(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close;

(C) The right to be represented by an attorney; and

(D) Any other information as the director may require.

(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close

was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from a determination order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f), the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was

timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (8) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's or a beneficiary's request for reconsideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) The director may delay the reconsideration proceeding and toll the reconsideration timeline established under subsection (6) of this section for up to 45 calendar days if:

(A) A request for reconsideration of a notice of closure has been made to the director within 60 days of the date of the notice of closure;

(B) The parties are actively engaged in settlement negotiations that include issues in dispute at reconsideration;

(C) The parties agree to the delay; and

(D) Both parties notify the director before the 18th working day after the reconsideration proceeding has begun that they request a delay under this subsection.

(b) A delay of the reconsideration proceeding granted by the director under this subsection expires:

(A) If a party requests the director to resume the reconsideration proceeding before the expiration of the delay period;

(B) If the parties reach a settlement and the director receives a copy of the approved settlement documents before the expiration of the delay period; or

(C) On the next calendar day following the expiration of the delay period authorized by the director.

(c) Upon expiration of a delay granted under this subsection, the timeline for the completion of the reconsideration proceeding shall resume as if the delay had never been granted.

(d) Compensation due the worker shall continue to be paid during the period of delay authorized under this subsection.

(e) The director may authorize only one delay period for each reconsideration proceeding.

(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If the director determines that insufficient medical information is available to determine disability, the director may appoint, and refer the claim to, a medical arbiter.

(c) At the request of either of the parties, the director shall appoint a panel of as many as three medical arbiters in accordance with criteria that the director sets by rule.

(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, the worker may not attend a medical arbiter examination for this claim closure. The reconsideration record must be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended under this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, are not due and payable to the worker.

(f) The insurer or self-insured employer shall pay the costs of examination and review by the medical arbiter or panel of medical arbiters.

(g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter before completing the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(9) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due for work disability under the closure shall be suspended, and the worker shall receive temporary disability compensation and any permanent disability payments

due for impairment while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(11) If the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(13) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(14)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(15) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured employer may not recover an overpayment from a worker's permanent partial disability compensation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total compensation awarded to the worker.

(b) An insurer or self-insured employer may not declare an overpayment of any compensation that was paid more than two years prior to the date of the declaration.

SECTION 57. ORS 656.325 is amended to read:

656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. No more than three independent medical examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

(b) When a worker is requested by the director, the insurer or self-insured employer to attend an independent medical examination, the examination must be conducted by a physician selected from a list of qualified physicians established by the director under ORS 656.328.

(c) The director shall adopt rules applicable to independent medical examinations conducted pursuant to paragraph (a) of this subsection that:

(A) Provide a worker the opportunity to request review by the director of the reasonableness of the location selected for an independent medical examination. Upon receipt of the request for review, the director shall conduct an expedited review of the location selected for the independent medical examination and issue an order on the reasonableness of the location of the examination. The director shall determine if there is substantial evidence for the objection to the location for the independent medical examination based on a conclusion that the required travel is medically contraindicated or other good cause establishing that the required travel is unreasonable. The determinations of the director about the location of independent medical examinations are not subject to review.

(B) Impose a monetary penalty against a worker who fails to attend an independent medical examination without prior notification or without justification for not attending the examination. A penalty imposed under this subparagraph may be imposed only on a worker who is not receiving temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may offset any future compensation payable to the worker to recover any penalty imposed under this subparagraph from a claim with the same insurer or self-insured employer. When a penalty is recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment may not exceed 25 percent of the benefit payment without prior authorization from the worker.

(C) Impose a sanction against a medical service provider that unreasonably fails to provide in a timely manner diagnostic records required for an independent medical examination.

(d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for an independent medical examination is unreasonable, the insurer or self-insured employer shall accept or deny the claim within 90 days after the employer has notice or knowledge of the claim.

(e) If the worker has made a timely request for a hearing on a denial of compensability as required by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pursuant to paragraph (a) of this subsection and the worker's attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] does not concur with the report or reports, the worker may request an examination to be conducted by a physician selected by the director from the list described in ORS 656.328. The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.

(f) The insurer or self-insured employer shall pay the costs of the medical examination and related services which are reasonably necessary to allow the worker to submit to any examination requested under this section. As used in this paragraph, "related services" includes, but is not limited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages for the period during which the worker is absent if the worker does not receive benefits pursuant to ORS 656.210 (4) during the period of absence. A claim for "related services" described in this paragraph shall be made in the manner prescribed by the director.

(g) A worker who objects to the location of an independent medical examination must request review by the director under paragraph (c)(A) of this subsection within six business days of the date the notice of the independent medical examination was mailed.

(2) For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal.

(3) A worker who has received an award for permanent total or permanent partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268.

(4) When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to this chapter, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate.

(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*], after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered.

(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers.

(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] approves employment in a

modified job whether or not such a job is available.

(6) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

SECTION 58. ORS 656.340 is amended to read:

656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be provided to an injured worker who is eligible for assistance in returning to work.

(b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for vocational assistance within five days of:

(A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical or investigation report, notification from the worker, or otherwise; or

(B) The time the worker is medically stationary, if the worker has not returned to or been released for the worker's regular employment or has not returned to other suitable employment with the employer at the time of injury or aggravation and the worker is not receiving vocational assistance.

(c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new information that would change the eligibility determination.

(2) Contact under subsection (1) of this section shall include informing the worker about reemployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job site modification assistance and the provisions of the preferred worker program pursuant to rules adopted by the Director of the Department of Consumer and Business Services.

(3) Within five days after notification that the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has released a worker to return to work, the insurer or self-insured employer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the employer of the worker's reemployment rights, wage subsidy and the job site modification assistance and the provisions of the preferred worker program.

(4) As soon as possible, and not more than 30 days after the contact required by subsection (1) of this section, the insurer or self-insured employer shall cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance. The insurer or self-insured employer shall notify the worker of the decision regarding the worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the worker is not eligible, the worker may apply to the director for review of the decision as provided in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under standards prescribed by the director, may not be found eligible thereafter unless that eligibility determination is rejected by the director under subsection (16) of this section or the worker's condition worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for such benefits arises from a worsening of the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS 656.273.

(5) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the weekly wage currently being paid for employment which was the worker's regular employment even though the wage available following employment may be less than the wage prescribed by subsection (6) of this section. As used in this subsection and subsection (6) of this section, "regular employment"

means the employment the worker held at the time of the injury or the claim for aggravation under ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of the aggravation, the employment the worker held on the last day of work prior to the aggravation.

(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A "substantial handicap to employment" exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) "Suitable employment" means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and

(iii) Employment that produces a weekly wage within 20 percent of that currently being paid for employment that was the worker's regular employment as defined in subsection (5) of this section. The director shall adopt rules providing methods of calculating the weekly wage currently being paid for the worker's regular employment for use in determining eligibility and for providing assistance to eligible workers. If the worker's regular employment was seasonal or temporary, the worker's wage shall be averaged based on a combination of the worker's earned income and any unemployment insurance payments. Only earned income evidenced by verifiable documentation such as federal or state tax returns shall be used in the calculation. Earned income does not include fringe benefits or reimbursement of the worker's employment expenses.

(7) Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training.

(8) An insurer or self-insured employer may utilize its own staff or may engage any other individual certified by the director to perform the vocational evaluation required by subsection (4) of this section.

(9) The director shall adopt rules providing:

(a) Standards for and methods of certifying individuals qualified by education, training and experience to provide vocational assistance to injured workers;

(b) Standards for registration of vocational assistance providers;

(c) Conditions and procedures under which the certification of an individual to provide vocational assistance services or the registration of a vocational assistance provider may be suspended or revoked for failure to maintain compliance with the certification or registration standards;

(d) Standards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work; and

(e) Procedures, schedules and conditions relating to the payment for services performed by a vocational assistance provider, that are based on payment for specific services performed and not

fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for direct worker purchases and for all vocational assistance providers and shall be the same within suitable geographic areas.

(10) Insurers and self-insured employers shall maintain records and make reports to the director of vocational assistance actions at times and in the manner as the director may prescribe. The requirements prescribed shall be for the purpose of assisting the Department of Consumer and Business Services in monitoring compliance with this section to insure that workers receive timely and appropriate vocational assistance. The director shall minimize to the greatest extent possible the number, extent and kinds of reports required. The director shall compile a list of organizations or agencies registered to provide vocational assistance. A current list shall be distributed by the director to all insurers and self-insured employers. The insurer shall send the list to each worker with the notice of eligibility.

(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer shall notify the director and the director shall select a provider. Any change in the choice of vocational assistance provider is subject to the approval of the director.

(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months. The insurer or self-insured employer may voluntarily extend the payment of temporary disability compensation to a maximum of 21 months. The director may order the payment of temporary disability compensation for up to 21 months upon good cause shown by the injured worker. The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months.

(13) As used in this section, "vocational assistance provider" means a public or private organization or agency that provides vocational assistance to injured workers.

(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the same type or extent of assistance.

(b) Training shall not be provided to an eligible worker solely because the worker cannot obtain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage significantly closer to that prescribed in subsection (6) of this section.

(c) Nothing in this section shall be interpreted to expand the availability of training under this section.

(15) A physical capacities evaluation shall be performed in conjunction with vocational assistance or determination of eligibility for such assistance at the request of the insurer or self-insured employer or worker. The request shall be made to the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*]. [*The attending physician or nurse practitioner,*] Within 20 days of the request, **the attending physician** shall perform a physical capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer and the worker in writing that the injured worker is incapable of participating in a physical capacities evaluation.

(16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process.

Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director shall adopt by rule a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter. Application for review must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time.

(c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. The agreement is subject to reconsideration by the director under limitations prescribed by the director, but is not subject to review by any other forum.

(d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order based on a record sufficient to permit review. The order is subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the date the order was issued. At the hearing, the order of the director shall be modified only if it:

(A) Violates a statute or rule;

(B) Exceeds the statutory authority of the agency;

(C) Was made upon unlawful procedure; or

(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(e) For purposes of this subsection, the term "parties" does not include a noncomplying employer.

SECTION 59. ORS 656.726 is amended to read:

656.726. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other docu-

ments shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter and to require the electronic transmission and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS 656.704. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. Permanent impairment is expressed as a percentage of the whole person. The impairment value may not exceed 100 percent of the whole person.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment as modified by the factors of age, education and adaptability to perform a given job.

(D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall, in the order on reconsideration, determine the extent of permanent disability that addresses the worker's impairment.

(E) Notwithstanding any other provision of this section, only impairment benefits shall be awarded under ORS 656.214 if the worker has been released to regular work by the attending physician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*] or has returned to regular work at the job held at the time of injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

(5)(a) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(b) Notwithstanding any other provision of this chapter, the board may adopt rules to allow for the electronic transmission of filings, reports, notices and other documents required to be filed under the board's authority.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity.

SECTION 60. ORS 656.797 is amended to read:

656.797. On or after October 1, 2004, **prior to providing compensable medical services or authorizing temporary disability benefits,** a nurse practitioner licensed under ORS 678.375 to 678.390[*, prior to providing compensable medical services or authorizing temporary disability benefits under ORS 656.245,*] must certify in a form acceptable to the Director of the Department of Consumer and Business Services that the nurse practitioner has reviewed the materials developed under ORS 656.795.

SECTION 61. ORS 659A.043 is amended to read:

659A.043. (1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. A worker's former position is available even if that position has been filled by a replacement while the injured worker was absent. If the former position is not available, the

worker shall be reinstated in any other existing position that is vacant and suitable. A certificate by the attending physician**, as defined in ORS 656.005 (12),** [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] that the **attending** physician [*or nurse practitioner*] approves the worker's return to the worker's regular employment or other suitable employment shall be prima facie evidence that the worker is able to perform such duties.

(2) Such right of reemployment shall be subject to the provisions for seniority rights and other employment restrictions contained in a valid collective bargaining agreement between the employer and a representative of the employer's employees.

(3) Notwithstanding subsection (1) of this section:

(a) The right to reinstatement to the worker's former position under this section terminates when whichever of the following events first occurs:

[*(A) A medical determination by the attending physician or, after an appeal of such determination to a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656, has been made that the worker cannot return to the former position of employment.*]

(A) The worker cannot return to the former position of employment according to:

(i) The medical determination of the attending physician; or

(ii) Upon appeal of the attending physician's determination, the determination of a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.

(B) The worker is eligible and participates in vocational assistance under ORS 656.340.

(C) The worker accepts suitable employment with another employer after becoming medically stationary.

(D) The worker refuses a bona fide offer from the employer of light duty or modified employment that is suitable prior to becoming medically stationary.

(E) Seven days elapse from the date that the worker is notified by the insurer or self-insured employer by certified mail that the worker's attending physician [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has released the worker for employment unless the worker requests reinstatement within that time period.

(F) Three years elapse from the date of injury.

(b) The right to reinstatement under this section does not apply to:

(A) A worker hired on a temporary basis as a replacement for an injured worker.

(B) A seasonal worker employed to perform less than six months' work in a calendar year.

(C) A worker whose employment at the time of injury resulted from referral from a hiring hall operating pursuant to a collective bargaining agreement.

(D) A worker whose employer employs 20 or fewer workers at the time of the worker's injury and at the time of the worker's demand for reinstatement.

(4) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under subsection (3)(a)(D) of this section and who otherwise is entitled to family leave under ORS 659A.150 to 659A.186:

(a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon refusing the offer of employment; and

(b) Need not give additional written or oral notice to the employer that the employee is commencing a period of family leave.

(5) Any violation of this section is an unlawful employment practice.

SECTION 62. ORS 659A.046 is amended to read:

659A.046. (1) A worker who has sustained a compensable injury and is disabled from performing

the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable.

(2) A certificate of the worker's attending physician**, as defined in ORS 656.005 (12),** [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] that the worker is able to perform described types of work shall be prima facie evidence of such ability.

(3) Notwithstanding subsection (1) of this section, the right to reemployment under this section terminates when whichever of the following events first occurs:

[*(a) The worker cannot return to reemployment at any position with the employer either by determination of the attending physician or a nurse practitioner authorized to provide compensable medical services under ORS 656.245 or upon appeal of that determination, by determination of a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.*]

(a) The worker cannot return to reemployment at any position with the employer according to:

(A) The determination of the attending physician; or

(B) Upon appeal of the attending physician's determination, the determination of a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.

(b) The worker is eligible and participates in vocational assistance under ORS 656.340.

(c) The worker accepts suitable employment with another employer after becoming medically stationary.

(d) The worker refuses a bona fide offer from the employer of light duty or modified employment that is suitable prior to becoming medically stationary.

(e) Seven days elapse from the date that the worker is notified by the insurer or self-insured employer by certified mail that the worker's attending physician [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has released the worker for reemployment unless the worker requests reemployment within that time period.

(f) Three years elapse from the date of injury.

(4) Such right of reemployment shall be subject to the provisions for seniority rights and other employment restrictions contained in a valid collective bargaining agreement between the employer and a representative of the employer's employees.

(5) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under subsection (3)(d) of this section and who otherwise is entitled to family leave under ORS 659A.150 to 659A.186:

(a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon refusing the offer of employment; and

(b) Need not give additional written or oral notice to the employer that the employee is commencing a period of family leave.

(6) Any violation of this section is an unlawful employment practice.

(7) This section applies only to employers who employ six or more persons.

SECTION 63. ORS 659A.049 is amended to read:

659A.049. The rights of reinstatement **and reemployment** afforded by ORS 659A.043 and 659A.046 shall not be forfeited if the worker refuses to return to the worker's regular or other offered employment without release to such employment by the worker's attending physician **as defined in ORS 656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*].

SECTION 64. ORS 659A.063 is amended to read:

659A.063. (1) The State of Oregon shall cause group health benefits to continue in effect with respect to that worker and any covered dependents or family members by timely payment of the premium that includes the contribution due from the state under the applicable benefit plan, subject to any premium contribution due from the worker that the worker paid before the occurrence of the injury or illness. If the premium increases or decreases, the State of Oregon and worker contributions shall be adjusted to remain consistent with similarly situated active employees. The State of Oregon shall continue the worker's health benefits in effect until whichever of the following events occurs first:

(a) The worker's attending physician **as defined in ORS 656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has determined the worker to be medically stationary and a notice of closure has been entered;

(b) The worker returns to work for the State of Oregon, after a period of continued coverage under this section, and satisfies any probationary or minimum work requirement to be eligible for group health benefits;

(c) The worker takes full- or part-time employment with another employer that is comparable in terms of the number of hours per week the worker was employed with the State of Oregon or the worker retires;

(d) Twelve months have elapsed since the date the State of Oregon received notice that the worker filed a workers' compensation claim pursuant to ORS chapter 656;

(e) The claim is denied and the claimant fails to appeal within the time provided by ORS 656.319 or the Workers' Compensation Board or a workers' compensation hearings referee or a court issues an order finding the claim is not compensable;

(f) The worker does not pay the required premium or portion thereof in a timely manner in accordance with the terms and conditions under this section;

(g) The worker elects to discontinue coverage under this section and notifies the State of Oregon in writing of this election;

(h) The worker's attending physician [*or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] has released the worker to modified or regular work, the work has been offered to the worker and the worker refuses to return to work; or

(i) The worker has been terminated from employment for reasons unrelated to the workers' compensation claim.

(2) If the workers' compensation claim of a worker for whom health benefits are provided pursuant to subsection (1) of this section is denied and the worker does not appeal or the worker appeals and does not prevail, the State of Oregon may recover from the worker the amount of the premiums plus interest at the rate authorized by ORS 82.010. The State of Oregon may recover the payments through a payroll deduction not to exceed 10 percent of gross pay for each pay period.

(3) The State of Oregon shall notify the worker of the provisions of ORS 659A.060 to 659A.069, and of the remedies available for breaches of ORS 659A.060 to 659A.069, within a reasonable time after the State of Oregon receives notice that the worker will be absent from work as a result of an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter 656. The notice from the State of Oregon shall include the terms and conditions of the continuation of health benefits and what events will terminate the coverage.

(4) If the worker fails to make timely payment of any premium contribution owing, the State of Oregon shall notify the worker of impending cancellation of the health benefits and provide the worker with 30 days to pay the required premium prior to canceling the policy.

(5) It is an unlawful employment practice for the State of Oregon to discriminate against a worker, as defined in ORS 659A.060, by terminating the worker's group health benefits while that worker is absent from the place of employment as a result of an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter 656, except as provided for in this section.

SECTION 65. ORS 657.170 is amended to read:

657.170. (1) If the Director of the Employment Department finds that during the base year of the individual any individual has been incapable of work during the greater part of any calendar quarter, such base year shall be extended a calendar quarter. Except as provided in subsection (2) of this section, no such extension of an individual's base year shall exceed four calendar quarters.

(2) If the director finds that during and prior to the individual's base year the individual has had a period of temporary total disability caused by illness or injury and has received compensation under ORS chapter 656 for a period of temporary total disability during the greater part of any calendar quarter, the individual's base year shall be extended as many calendar quarters as necessary to establish a valid claim, up to a maximum of four calendar quarters prior to the quarter in which the illness or injury occurred, if the individual:

(a) Files a claim for benefits not later than the fourth calendar week of unemployment following whichever is the latest of the following dates:

(A) The date the individual is released to return to work by the attending physician[*, as defined in ORS chapter 656, or a nurse practitioner authorized to provide compensable medical services under ORS 656.245*] **as defined in ORS 656.005 (12)**; or

(B) The date of mailing of a notice of claim closure pursuant to ORS chapter 656; and

(b) Files such a claim within the three-year period immediately following the commencement of such period of illness or injury.

(3) Notwithstanding the provisions of this section, benefits payable as a result of the use of wages paid in a calendar quarter prior to the individual's current base year shall not exceed one-third of such wages less benefits paid previously as a result of the use of such wages in computing a previous benefit determination.

CAPTIONS

SECTION 66. The unit captions used in this 2026 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2026 Act.

EFFECTIVE DATE

SECTION 67. This 2026 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect on its passage.
