

HB 4040-36
(LC 241)
2/16/26 (RH/ps)

Requested by HOUSE COMMITTEE ON HEALTH CARE (at the request of Representative Rob Nosse)

**PROPOSED AMENDMENTS TO
HOUSE BILL 4040**

1 On page 2 of the printed bill, line 1, after “provisions;” delete the rest
2 of the line and lines 2 through 6 and insert “amending ORS 411.447, 414.211,
3 414.690, 427.191, 442.615, 475A.325, 475A.338, 475A.372, 646A.694, 656.005,
4 656.214, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340, 656.726,
5 656.797, 657.170, 659A.043, 659A.046, 659A.049, 659A.063, 678.733, 679.025,
6 685.100, 685.102, 743A.145, 743B.456, 744.702, 750.055 and 750.333 and section
7 5, chapter 575, Oregon Laws 2015; repealing ORS 743B.221; and declaring an
8 emergency.”.

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

10

11

“HOSPITALS

12

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

14 “442.615. (1) As used in this section:

15 “(a) ‘Financial assistance’ includes:

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

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

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

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

1 patient:

2 “(a) Is uninsured;

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

4 “(c) Owes the hospital more than [~~\$500~~] **\$1,500 for a single hospital en-**
5 **counter.**

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

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

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

13 “(c) Require a hospital, before sending a bill to the patient, to conduct
14 the screening and apply any financial assistance for which the patient qual-
15 ifies to the bill; and

16 “(d) Require the hospital to notify a patient if the patient has been
17 screened and to explain to the patient, in language approved by the author-
18 ity, how to apply for financial assistance if financial assistance was denied,
19 or how to apply for additional financial assistance above what the patient
20 received.

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

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

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

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

29 “(5) A hospital may require a patient who applies for financial assistance
30 under subsection (4) of this section to provide documentation or verification

1 of information reported as necessary for the hospital to determine the
2 patient's eligibility for financial assistance.

3 “(6) If a patient applies for financial assistance after having paid for the
4 services and the patient is found to have been eligible for financial assist-
5 ance when the services were provided:

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

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

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

18 “(7) If a patient applies for financial assistance and the hospital deter-
19 mines that the patient is eligible for financial assistance based on documen-
20 tation provided by the patient, the patient's eligibility for financial
21 assistance continues for nine months following the hospital's determination,
22 and the patient may not be required to reapply for financial assistance for
23 services provided during that nine-month period.

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

1 “(b) If a hospital denies a patient’s application for financial assistance,
2 whether in whole or in part, the hospital must notify the patient of the de-
3 nial and include in the notice an explanation of the hospital’s appeal process.

4 “(9) During the pendency of an appeal that is filed using a hospital’s ap-
5 peal process under subsection (8) of this section, if:

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

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

11
12 **“RESIDENTIAL CARE**

13
14 **“SECTION 2.** ORS 678.733 is amended to read:

15 “678.733. (1) The Health Licensing Office may issue a residential care fa-
16 cility administrator license to an applicant who:

17 “(a) Is at least 21 years of age;

18 “(b) Has earned at least a high school diploma or its equivalent, as indi-
19 cated by evidence of the following, in a form deemed sufficient by the office:

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

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

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

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

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

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

1 by rule;

2 “(e) Pays a licensure fee; and

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

4 “(2) Evidence of the education described in subsection (1)(b) of this sec-
5 tion may be provided by a diploma or other document, or by facts, circum-
6 stances or other indicators deemed sufficient by the office.

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

9 **“SECTION 3. The amendments to ORS 678.733 by section 2 of this**
10 **2026 Act apply to applications for licensure under ORS 678.733 submit-**
11 **ted to the Health Licensing Office on or after the operative date**
12 **specified in section 4 of this 2026 Act.**

13 **“SECTION 4. (1) The amendments to ORS 678.733 by section 2 of this**
14 **2026 Act become operative on January 1, 2027.**

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

21

22 **“MEDICAL ASSISTANCE**

23

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

25 **“411.447. (1) As used in this section, ‘correctional facility’ means:**

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

27 **“(b) A Department of Corrections institution as defined in ORS 421.005;**

28 or

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

30 **“(2) The Department of Human Services or the Oregon Health Authority**

1 shall:

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

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

7 “(3) Upon notification that a person described in subsection (2) of this
8 section is not residing in a correctional facility or that the person is admit-
9 ted to a medical institution outside of the correctional facility for a period
10 of hospitalization, the department or the authority shall reinstate the
11 *[person’s medical assistance if the person is eligible for medical assistance]*
12 **medical assistance benefits for which the person is eligible at the time**
13 **of release or hospitalization.**

14 “(4)(a) A designee of a correctional facility may apply for medical assist-
15 ance on behalf of a person, while the person is residing in the correctional
16 facility, for the purpose of establishing eligibility for medical assistance
17 **prior to release, with full benefits** upon the person’s release from the
18 correctional facility or during a period of hospitalization that will occur
19 outside of the correctional facility.

20 “(b) The designee may obtain information necessary to determine eligi-
21 bility for medical assistance, including the person’s Social Security number
22 or information that is not otherwise subject to disclosure under ORS 411.320
23 or 413.175. The information obtained under this paragraph may be used only
24 for the purpose of assisting the person in applying for medical assistance and
25 may not be redisclosed without the person’s authorization.

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

30 “(5) This section does not extend eligibility to an otherwise ineligible

1 person or extend medical assistance to a person if matching federal funds
2 are not available to pay for the medical assistance.

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

4 “414.690. (1) The Health Evidence Review Commission shall regularly so-
5 licit testimony and information from stakeholders representing consumers,
6 advocates, providers, carriers and employers in conducting the work of the
7 commission.

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

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

12 **“(B) A list of all recommendations before the commission for re-
13 view, including, but not limited to:**

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

15 **“(ii) A technology review; and**

16 **“(iii) Coverage guidance.**

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

20 **“[(2)] (3)(a) The commission shall actively solicit public involvement
21 through a public meeting process to guide health resource allocation deci-
22 sions [that includes, but is not limited to:], in which the public is invited
23 to testify in writing and in person. Except when more than 50 written
24 comments from the public are received, the authority shall post to the
25 commission’s website and provide each commission member with the
26 written comments received from the public no later than 48 hours af-
27 ter the close of the public comment period.**

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

30 **“[(a)] (A) Providing members of the public the opportunity to provide in-**

1 put on the selection of any vendor that provides research and analysis to the
2 commission; and

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

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

10 “(b) Except as provided in ORS 414.701, the commission may not rely upon
11 any quality of life in general measures, either directly or by considering re-
12 search or analysis that relies on a quality of life in general measure, in de-
13 termining:

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

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

16 “(C) The value of a service.

17 “(c) The list must be submitted by the commission pursuant to subsection
18 [~~(5)~~] **(6)** of this section and is not subject to alteration by any other state
19 agency.

20 “[~~(4)~~] **(5)** In order to encourage effective and efficient medical evaluation
21 and treatment, the commission:

22 “(a) May include clinical practice guidelines in its prioritized list of ser-
23 vices. The commission shall actively solicit testimony and information from
24 the medical community and the public to build a consensus on clinical
25 practice guidelines developed by the commission.

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

30 “(c) Shall consider both the clinical effectiveness and cost-effectiveness

1 of health services, including drug therapies, in determining their relative
2 importance using peer-reviewed medical literature.

3 “[5] (6) The commission shall report the prioritized list of services to the
4 Oregon Health Authority for budget determinations by July 1 of each even-
5 numbered year.

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

15 “[7] (8) The commission may alter the list during the interim only as
16 follows:

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

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

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

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

22 “[8] (9) If a service is deleted or added during an interim and no new
23 funding is required, the commission shall report to the Speaker of the House
24 of Representatives and the President of the Senate. However, if a service to
25 be added requires increased funding to avoid discontinuing another service,
26 the commission shall report to the Emergency Board to request the funding.

27 “[9] (10) The prioritized list of services remains in effect for a two-year
28 period beginning no earlier than October 1 of each odd-numbered year.

29 “[10](a) (11)(a) As used in this section, ‘peer-reviewed medical
30 literature’ means scientific studies printed in journals or other publications

1 that publish original manuscripts only after the manuscripts have been crit-
2 ically reviewed by unbiased independent experts for scientific accuracy, va-
3 lidity and reliability.

4 “(b) ‘Peer-reviewed medical literature’ does not include internal publica-
5 tions of pharmaceutical manufacturers.

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

7 “414.211. (1) There is established a Medicaid Advisory Committee con-
8 sisting of not more than 15 members appointed by the Governor.

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

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

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

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

16 “(d) The Director of the Oregon Health Authority or [*designee*] **a man-**
17 **ager of the division of the authority that administers the state medical**
18 **assistance program;**

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

20 “(f) Health care providers;

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

24 “(h) Members of the general public.

25 “(3) In making appointments, the Governor shall consult with appropriate
26 professional and other interested organizations. All members appointed to
27 the committee shall be familiar with the medical needs of low income per-
28 sons.

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

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

5 **“SECTION 8. The amendments to ORS 414.211 by section 7 of this
6 2026 Act become operative on July 10, 2027.**

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

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

11 **“(2) For the period between July 10, 2026, and July 9, 2027, at least
12 20 percent Medicaid recipients.**

13 **“SECTION 10. Section 9 of this 2026 Act is repealed on January 2,
14 2028.**

15

16 **“PARENT PROVIDERS**

17

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

19 **“427.191. (1) As used in this section:**

20 **“(a) ‘Agency’ means an agency that hires, trains and supervises direct
21 support professionals using state funds received from the Department of
22 Human Services.**

23 **“(b) ‘Attendant care services’ means services provided directly to an in-
24 dividual with a disability to assist with activities of daily living, instru-
25 mental activities of daily living and health-related tasks.**

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

27 **“(A) Has a developmental or intellectual disability; or**

28 **“(B) Meets the eligibility criteria to receive services under the Medically
29 Fragile (Hospital) Model Waiver or the Medically Involved Children’s
30 Waiver approved by the Centers for Medicare and Medicaid Services under**

1 42 U.S.C. 1396n(c).

2 “(d) ‘Client’ means an individual who receives attendant care services.

3 “(e) ‘Client child’ means a child who receives attendant care services from
4 the child’s parent.

5 “(f) ‘Developmental disability services’ has the meaning given that term
6 in ORS 427.101.

7 “(g) ‘Direct support professional’ means an individual who is hired, em-
8 ployed, trained, paid and supervised by an agency to provide attendant care
9 services to a client of the agency.

10 “(h) ‘Nonparent caregiver’ means a direct support professional, personal
11 support worker or similar provider who is paid to provide attendant care
12 services to clients who are not the provider’s children.

13 “(i) ‘Parent’ includes a:

14 “(A) Natural or adoptive parent of a child;

15 “(B) Stepparent of a child; and

16 “(C) Legal guardian of a child.

17 “(j)(A) ‘Parent provider’ means a parent who is paid to provide attendant
18 care services to the parent’s minor child.

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

21 “(k)(A) ‘Personal support worker’ means an individual who is employed
22 by a client or the client’s representative and paid to provide attendant care
23 services to the client.

24 “(B) ‘Personal support worker’ does not include a direct support profes-
25 sional.

26 “(L) ‘State plan’ means Oregon’s state plan for medical assistance, de-
27 scribed in 42 U.S.C. 1396a, approved by the Centers for Medicare and
28 Medicaid Services.

29 “(m) ‘Very high behavioral needs’ means a minor child’s extraordinary
30 needs for support due to the child’s behavioral condition as indicated by a

1 federally approved functional needs assessment adopted by the department
2 that assigns the child to the highest service level.

3 “(n) ‘Very high medical needs’ means a minor child’s extraordinary needs
4 for support due to the child’s medical condition as indicated by a federally
5 approved functional needs assessment adopted by the department that assigns
6 the child to the highest service level.

7 “(2) Subject to rules adopted under subsection (8) of this section, to ORS
8 427.194 and to available funding, the department shall administer a program
9 to compensate parents to provide attendant care services to the parents’
10 children who have been assessed by the department to have very high med-
11 ical or very high behavioral needs.

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

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

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

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

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

24 “(B) Shall pay parent providers overtime at the same rate and under the
25 same circumstances as direct support professionals who are not parent pro-
26 viders;

27 “(C) Except as authorized by the department by rule, may not pay pro-
28 viders of attendant care services, including parent providers, to provide ser-
29 vices to a [*minor*] child during school hours unless the [*minor*] child is
30 temporarily at home recovering from surgery or illness and the temporary

1 absence from school is recommended by the child’s health care provider; and

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

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

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

10 “(iii) Enroll the [*client*] child in a private school that offers fewer school
11 hours than the school hours offered by the local public school to the major-
12 ity of students in the same grade as the [*client*] child.

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

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

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

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

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

29 “(A) Grocery shopping for the household;

30 “(B) Housekeeping not required for the disability-related support needs

1 of the client child;

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

3 “(D) Transporting individuals other than the client child to or from ac-
4 tivities or appointments.

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

9 The assignment:

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

11 “(b) Must clearly state that the assignment is limited to decisions re-
12 garding the development and implementation of the **client** child’s individual
13 support plan and does not limit the authority of the parent provider to make
14 decisions for the client child with respect to health care, education or reli-
15 gious training.

16 “(7) A parent provider is subject to the requirements of mandatory re-
17 porting of abuse under ORS 124.060 and 419B.010, 24 hours per day, seven
18 days per week.

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

25 “(a) Strategies to safeguard nonparent caregivers and avoid the displace-
26 ment of nonparent caregivers by parent providers;

27 “(b) Requirements for agencies to demonstrate consistent efforts to re-
28 cruit, train and retain nonparent caregivers;

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

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

7 “(B) Client children to learn to advocate for themselves with respect to
8 choosing and managing direct support professionals before and after reaching
9 18 years of age; and

10 “(C) Community developmental disability programs related to the em-
11 ployment of parent providers, including on how to support families to man-
12 age issues concerning conflicts of interest, provider recruitment and
13 retention and the empowerment of the client child to have a meaningful
14 voice in the selection of the client child’s *[direct support professionals]*
15 **caregivers;**

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

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

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

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

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

28 “(9) The department may adopt rules necessary to manage the cost, size
29 and growth rate of the program described in this section that are necessary
30 to protect the eligibility for and levels of services under programs serving

1 individuals receiving developmental disability services provided for in the
2 state plan, including the development of criteria to limit the number of
3 children eligible to participate in the program.

4 “(10) Annually, the department shall report to the interim committees of
5 the Legislative Assembly related to human services or, if the Legislative
6 Assembly is in session, to the committees of the Legislative Assembly related
7 to human services, in the manner provided in ORS 192.245, updates on the
8 program described in this section, including:

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

12 “(b) The number of hours of attendant care services provided by parent
13 providers and number of hours of attendant care services provided by non-
14 parent caregivers;

15 “(c) A comparison of the cost per child of providing attendant care ser-
16 vices by parent providers under the program with the cost per child of pro-
17 viding attendant care services by nonparent caregivers; and

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

21

22

“DENTAL

23

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

25 “679.025. (1) A person may not practice dentistry or purport to be a den-
26 tist without a valid license to practice dentistry issued by the Oregon Board
27 of Dentistry.

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

29 “(a) Dentists licensed in another state or country making a clinical pres-
30 entation sponsored by a bona fide dental society or association or an ac-

1 credited dental educational institution approved by the board.

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

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

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

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

30 “(f) Instructors of dentistry, whether full- or part-time, while exclusively

1 engaged in teaching activities and while employed in accredited dental edu-
2 cational institutions.

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

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

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

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

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

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

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

20 “(m) A person licensed as a denturist under ORS 680.500 to 680.565 en-
21 gaged in the practice of denture technology.

22 “(n) An expanded practice dental hygienist who renders services author-
23 ized by a permit issued by the board pursuant to ORS 680.200.

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

26 **“(2) The Oregon Board of Dentistry make take any action before the**
27 **operative date specified in subsection (1) of this section that is neces-**
28 **sary to enable the board to exercise, on and after the operative date**
29 **specified in subsection (1) of this section, all of the duties, functions**
30 **and powers conferred on the board by the amendments to ORS 679.025**

1 by section 12 of this 2026 Act.

2

3

“COMMERCIAL HEALTH INSURANCE

4

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

7 **“SECTION 15. (1) A group or individual policy of casualty insurance**
8 **or health insurance, including a health benefit plan as defined in ORS**
9 **743B.005, shall provide coverage for medically necessary anesthesia**
10 **services, regardless of the duration, for any procedure covered by the**
11 **policy.**

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

15 **“SECTION 16. Section 15 of this 2026 Act applies to group or indi-**
16 **vidual policies of casualty insurance or health insurance, including**
17 **health benefit plans, that are issued, renewed or extended on or after**
18 **January 1, 2027.**

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

21 **“SECTION 18. As used in ORS 743B.456 and sections 20 and 21 of this**
22 **2026 Act:**

23 **“(1) ‘Dental insurance plan’ means a policy or certificate of insur-**
24 **ance or other contract that provides only a dental benefit.**

25 **“(2) ‘Dental insurer’ means an insurer that offers a policy or cer-**
26 **tificate of insurance or other contract that provides only a dental**
27 **benefit.**

28 **“(3) ‘Dental provider’ means a person licensed, certified or other-**
29 **wise permitted by laws of this state to administer dental services in**
30 **the ordinary course of business or practice of a profession.**

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

2 “743B.456. (1) As used in this section, [*‘dental insurer’ means an insurer*
3 *that offers a policy or certificate of insurance or other contract, that provides*
4 *only a dental benefit*] **‘clean claim’ means a claim that has no defect or**
5 **error, is understandable and reasonably legible, includes required**
6 **substantiating documentation and does not require special treatment**
7 **that delays timely payment on the claim.**

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

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

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

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

20 “(3) If a dental insurer contracts with a vendor to process payments of
21 dental providers’ claims, the dental insurer shall require the vendor to com-
22 ply with the provisions of subsection (2)(a) of this section.

23 **“(4) Except as provided in this subsection, when a claim under a**
24 **dental insurance plan is submitted to a dental insurer by a dental**
25 **provider on behalf of a beneficiary, the dental insurer shall pay a clean**
26 **claim or deny the claim not later than 45 days after the date on which**
27 **the dental insurer receives the claim. If a dental insurer requires ad-**
28 **ditional information before payment of a claim, not later than 45 days**
29 **after the date on which the dental insurer receives the claim, the**
30 **dental insurer shall notify the beneficiary and the dental provider in**

1 writing or electronically, and give the beneficiary and the dental pro-
2 vider an explanation of the additional information needed to process
3 the claim. The dental insurer shall pay a clean claim or deny the claim
4 not later than 45 days after the date on which the dental insurer re-
5 ceives the additional information.

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

10 “(6) A dental insurer shall establish a method of communicating to
11 dental providers the procedures and information necessary to complete
12 claim forms. The procedures and information must be reasonably ac-
13 cessible to dental providers.

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

16 **“SECTION 20.** (1) As used in this section, ‘refund’ means the re-
17 turn, either directly or through an offset to a future claim, of some
18 or all of a payment already received by a dental provider.

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

22 “(a) Request from a dental provider a refund of a payment previ-
23 ously made to satisfy a claim unless the dental insurer:

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

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

30 “(b) Request that a contested refund be paid earlier than six months

1 after the dental provider receives the request.

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

5 “(a) Request from a dental provider a refund of a payment previ-
6 ously made to satisfy a claim unless the dental insurer:

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

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

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

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

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

23 “(5) A dental insurer may at any time request from a dental pro-
24 vider a refund of a payment previously made to satisfy a claim if:

25 “(a) A third party, including a government entity, is found respon-
26 sible for satisfaction of the claim as a consequence of liability imposed
27 by law; and

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

1 **“(6) If a contract between a dental insurer and a dental provider**
2 **conflicts with this section, the provisions of this section prevail.**
3 **However, nothing in this section prohibits a dental provider from**
4 **choosing at any time to refund to a dental insurer any payment pre-**
5 **viously made to satisfy a claim.**

6 **“(7) This section neither permits nor precludes a dental insurer**
7 **from recovering from a subscriber, enrollee or beneficiary any**
8 **amounts paid to a dental provider for benefits to which the subscriber,**
9 **enrollee or beneficiary was not entitled under the terms and conditions**
10 **of the dental insurance plan, insurance policy or other benefit agree-**
11 **ment.**

12 **“SECTION 21. A dental provider that bills a dental insurer for cov-**
13 **ered services provided to an individual who is insured under a dental**
14 **insurance plan shall be reimbursed by the insurer by a direct payment**
15 **issued to the dental provider.**

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

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

25 **“(2) The Legislative Policy and Research Director shall develop, as**
26 **a pilot program, an insurance coverage mandate impact statement**
27 **template. The template must solicit the information sought in section**
28 **24 of this 2026 Act and must take into consideration:**

29 **“(a) Sources of data to be considered in the preparation of an in-**
30 **surance coverage mandate impact statement for proposed legislation;**

1 and

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

4 “(3) In preparing the template, the director shall consider models
5 used in other states and in academic research for assessing the im-
6 pacts of proposed insurance coverage mandate legislation and other
7 formal actions undertaken by national, state and local government
8 entities and other entities in the United States, including educational
9 institutions.

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

16 “(5) Following selection of the measures described in subsection (4)
17 of this section, the director shall apply the template to each of the
18 selected measures and prepare draft insurance coverage mandate im-
19 pact statements for each measure. The director shall present a pre-
20 liminary report to the committees with jurisdiction over health care
21 on or before September 15, 2026, that reports on:

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

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

24 and

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

27 “(6) Based on feedback provided by the committees with jurisdiction
28 over health care, the director may modify the template and prepare
29 final insurance coverage mandate impact statements on the test
30 measures. The director shall present the final impact statements and

1 the final process report summarizing the methodology used to prepare
2 and review impact statements to the policy committees that had heard
3 the test measures during the 2025 regular session of the Legislative
4 Assembly. The director shall present the statements and final report
5 to the committees on or before December 15, 2026.

6 “(7) Following the presentations described in subsection (5) of this
7 section and following or contemporaneously with the presentations
8 described in subsection (6) of this section and taking into account
9 provided feedback, the director shall propose to the committees with
10 jurisdiction over health care a policy that describes the objectives,
11 content and form of an insurance coverage mandate impact statement
12 and the procedures to be followed in the preparation of those state-
13 ments. After conducting due deliberations in which the committees
14 may make modifications to the policy, the committees shall adopt a
15 policy on the preparation of insurance coverage mandate impact
16 statements. The policy shall include guidance on when an insurance
17 coverage mandate impact statement must be posted online on the
18 Legislative Assembly website, relative to the location in the legislative
19 process of the associated legislative measure.

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

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

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

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

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

1 “(5) Whether the coverage under the proposed measure is an es-
2 sential health benefit as defined in ORS 731.097;

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

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

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

15 “(9) The extent to which a lack of the coverage in the proposed
16 measure results in financial hardship to residents of this state.

17 “SECTION 25. No later than September 15, 2027, the Legislative
18 Policy and Research Director shall report to the Legislative Assembly
19 in the manner provided under ORS 192.245 on recommendations for
20 changes to improve upon the review of proposed insurance coverage
21 mandates during regular or special sessions of the Legislative Assem-
22 bly. The recommendations may include legislative proposals or expla-
23 nations of the need for additional resources.

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

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

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

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

1 31, 2027.

2 “[3] *The amendments to section 8 of this 2022 Act by section 14 of this 2022*
3 *Act become operative on December 31, 2027.*”]

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

5 “750.055. (1) The following provisions apply to health care service con-
6 tractors to the extent not inconsistent with the express provisions of ORS
7 750.005 to 750.095:

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

9 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,
10 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
11 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
12 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
13 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

14 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and
15 732.517 to 732.596, not including ORS 732.582, and ORS 732.650 to 732.689.

16 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to
17 733.680 and 733.695 to 733.780.

18 “(e) ORS 734.014 to 734.440.

19 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to
20 742.162 and 742.518 to 742.542.

21 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022,
22 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to
23 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,
24 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680
25 to 743.689, 743.788 and 743.790.

26 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,
27 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
28 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
29 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100,
30 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141,

1 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.171,
2 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
3 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws
4 2013.

5 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195,
6 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222,
7 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256,
8 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
9 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to
10 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.430, 743B.450,
11 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555,
12 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and 743B.800.

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

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

16 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
17 sultants; and

18 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
19 ministrators.

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

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

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

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

1 maintenance organization.

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

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

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

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

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

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

19 “750.055. (1) The following provisions apply to health care service con-
20 tractors to the extent not inconsistent with the express provisions of ORS
21 750.005 to 750.095:

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

23 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,
24 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
25 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
26 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
27 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

28 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and
29 732.517 to 732.596, not including ORS 732.582, and ORS 732.650 to 732.689.

30 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to

1 733.680 and 733.695 to 733.780.

2 “(e) ORS 734.014 to 734.440.

3 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to
4 742.162 and 742.518 to 742.542.

5 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022,
6 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to
7 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,
8 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680
9 to 743.689, 743.788 and 743.790.

10 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,
11 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
12 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
13 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100,
14 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141,
15 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.171,
16 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
17 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws
18 2013.

19 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195,
20 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222,
21 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256,
22 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
23 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to
24 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.430, 743B.445,
25 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550,
26 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and 743B.800.

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

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

30 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-

1 sultants; and

2 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
3 ministrators.

4 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
5 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
6 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

24 “(b) A health care service contractor’s classification as a domestic insur-
25 ance company under paragraph (a) of this subsection does not subject the
26 health care service contractor to ORS 734.510 to 734.710.

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

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

18 “750.055. (1) The following provisions apply to health care service con-
19 tractors to the extent not inconsistent with the express provisions of ORS
20 750.005 to 750.095:

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

22 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,
23 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
24 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
25 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
26 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

27 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and
28 732.517 to 732.596, not including ORS 732.582, and ORS 732.650 to 732.689.

29 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to
30 733.680 and 733.695 to 733.780.

1 “(e) ORS 734.014 to 734.440.

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

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

9 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,
10 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
11 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
12 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100,
13 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141,
14 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.171,
15 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
16 743A.260, 743A.310 and 743A.315.

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

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

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

28 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
29 sultants; and

30 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-

1 administrators.

2 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
3 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
4 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

22 “(b) A health care service contractor’s classification as a domestic insur-
23 ance company under paragraph (a) of this subsection does not subject the
24 health care service contractor to ORS 734.510 to 734.710.

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

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

30 “750.333. (1) The following provisions apply to trusts carrying out a mul-

1 tiple employer welfare arrangement:

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

3 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316,
4 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414,
5 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620,
6 731.640 to 731.652, 731.804, 731.808 and 731.844 to 731.992.

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

9 “(d) ORS 734.014 to 734.440.

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

11 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023,
12 743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and*
13 *743B.221*].

14 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034,
15 743A.036, 743A.040, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
16 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
17 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100,
18 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141,
19 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.171,
20 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
21 743A.252, 743A.260 and 743A.310.

22 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127),
23 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225,
24 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
25 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342,
26 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
27 743B.423, 743B.430, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555,
28 743B.601, 743B.607 and 743B.610.

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

30 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation

1 of insurance producers;

2 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
3 sultants; and

4 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
5 ministrators.

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

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

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

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

12 “(c) Contributions are premiums.

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

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

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

19 “750.333. (1) The following provisions apply to trusts carrying out a mul-
20 tiple employer welfare arrangement:

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

22 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316,
23 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414,
24 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620,
25 731.640 to 731.652, 731.804, 731.808 and 731.844 to 731.992.

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

28 “(d) ORS 734.014 to 734.440.

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

30 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023,

1 743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and*
2 *743B.221*].

3 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034,
4 743A.036, 743A.040, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
5 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
6 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100,
7 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141,
8 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.171,
9 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
10 743A.252, 743A.260 and 743A.310.

11 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127),
12 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225,
13 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
14 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342,
15 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
16 743B.423, 743B.430, 743B.445, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550,
17 743B.555, 743B.601, 743B.607 and 743B.610.

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

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

21 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
22 sultants; and

23 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
24 ministrators.

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

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

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

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

1 “(c) Contributions are premiums.

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

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

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

7 “743A.145. (1) As used in this section:

8 “(a) ‘Device’ means:

9 “(A) An orthotic device.

10 “(B) A prosthetic device.

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

14 “(c) ‘Prosthetic device’ means an artificial limb device or appliance de-
15 signed to replace in whole or in part an arm or a leg.

16 “(2) All individual and group health insurance policies providing coverage
17 for the expenses of hospital, medical or surgical services or supplies shall
18 provide coverage for devices. The coverage required by this subsection in-
19 cludes:

20 “(a) Devices that are determined to be medically necessary to restore or
21 maintain the ability to complete activities of daily living or essential job-
22 related activities [*and that are not solely for comfort or convenience*].

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

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

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

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

1 device; or

2 “(C) The device, or a part of the device, requiring repair and the cost of
3 the repair would be more than 60 percent of the cost of the replacement de-
4 vice or replacement part of the device.

5 “(d) Repair of a device or any part of a device, if the repair is determined
6 to be medically necessary, based on:

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

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

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

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

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

23 “(5) If the coverage under subsection (2) of this section is provided
24 through a managed care organization, the insured shall have access to med-
25 ically necessary clinical care and to devices and technology from not fewer
26 than two distinct Oregon prosthetic and orthotic providers in the managed
27 care organization’s provider network.

28 “(6) An individual or group health plan may not deny coverage for a
29 prosthetic or orthotic benefit for an insured with limb loss, impairment or
30 absence to restore or maintain the ability to perform a physical activity if

1 a benefit would be covered for medical or surgical intervention for a person
2 without limb loss, impairment or absence to restore or maintain the ability
3 to perform the same physical activity.

4 “(7) For coverage described in subsection (2)(c) of this section, an insurer
5 may require confirmation from the prescribing health care provider that the
6 coverage is medically necessary if the device, or any part of the device, re-
7 quires replacement and is less than three years old.

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

9 “(9) The coverage requirements described in subsections (2)(e), (6) and (7)
10 of this section do not apply to a health benefit plan offered by the Public
11 Employees’ Benefit Board or the Oregon Educators Benefit Board, unless the
12 plans offered by the Public Employees’ Benefit Board or the Oregon Educa-
13 tors Benefit Board elect to provide the coverage and provide notice to the
14 Department of Consumer and Business Services in the form and manner de-
15 scribed by the department by rule.

16

17

“PHARMACY

18

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

20 “744.702. (1) Subject to ORS 744.704, a person shall not transact business
21 or purport or offer to transact business as a third party administrator in this
22 state unless the person holds a third party administrator license issued by
23 the Director of the Department of Consumer and Business Services.

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

26 “(a) Directly or indirectly solicits or effects coverage of, underwrites,
27 collects charges or premiums from, or adjusts or settles claims on, residents
28 of this state or residents of another state from offices in this state, in con-
29 nection with life insurance or health insurance coverage; or

30 “(b) Acts as a pharmacy services administrative organization, as defined

1 in ORS 735.538, or as an organization that advises or represents pharmacies
2 that are members of the organization, or that enters into contracts on behalf
3 of members, in matters that are related to procuring or supplying pre-
4 scription drugs.

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

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

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

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

27 “(a) Whether the prescription drug has led to health inequities in com-
28 munities of color;

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

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

2 “(d) The estimated average monetary price concession, discount or rebate
3 the manufacturer provides to health insurance plans in this state or is ex-
4 pected to provide to health insurance plans in this state, expressed as a
5 percentage of the price for the prescription drug under review;

6 “(e) The estimated total amount of the price concession, discount or re-
7 bate the manufacturer provides to each pharmacy benefit manager licensed
8 in this state for the prescription drug under review, expressed as a percent-
9 age of the prices;

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

12 “(g) The estimated average price concession, discount or rebate the man-
13 ufacturer provides or is expected to provide to health insurance plans and
14 pharmacy benefit managers in this state for therapeutic alternatives;

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

18 “(i) The impact on patient access to the drug considering standard pre-
19 scription drug benefit designs in health insurance plans offered in this state;

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

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

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

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

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

1 “(3) The board shall accept testimony from patients and caregivers af-
2 fected by a condition or disease that is treated by a prescription drug under
3 review by the board and from individuals with scientific or medical training
4 with respect to the disease or condition.

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

13 “(b) As used in this subsection:

14 “(A) ‘Health utility’ means a measure of the degree to which having a
15 particular form of disease or disability or having particular functional limi-
16 tations negatively impacts the quality of life as compared to a state of per-
17 fect health, expressed as a number between zero and one.

18 “(B) ‘Quality-adjusted life-year’ is the product of a health utility multi-
19 plied by the extra months or years of life that a patient might gain as a re-
20 sult of a treatment.

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

23 “(a) Accessing pricing information collected by the department under ORS
24 646A.689 and 743.025;

25 “(b) Accessing data reported to the Oregon Health Authority under ORS
26 442.373;

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

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

30 “(6) The information used to conduct an affordability review may include

1 any document and research related to the introductory price or price in-
2 crease of a prescription drug, including life cycle management, net average
3 price in this state, market competition and context, projected revenue and
4 the estimated value or cost-effectiveness of the prescription drug.

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

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

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

11

12

“PSILOCYBIN

13

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

15 “475A.325. [*Facilitator license; fees; rules.*] (1) The facilitation of
16 psilocybin services is subject to regulation by the Oregon Health Authority.

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

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

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

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

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

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

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

29 “[*(g)*] (f) [*Must*] Meet the requirements of any rule adopted by the au-
30 thority under subsection (4) of this section.

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

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

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

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

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

12 **“(d) In order to meet the requirement described in subsection (2)(d)**
13 **of this section, allow an applicant to submit proof of completion of a**
14 **psilocybin service facilitator training program in another state if the**
15 **training program is approved by the regulatory body responsible for**
16 **regulating psilocybin service facilitator training programs in that**
17 **state, and the authority determines that the training program’s cur-**
18 **riculum meets or exceeds the standards adopted under ORS 475A.380.**

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

20 “(a) May not exceed, together with other fees collected under ORS
21 475A.210 to 475A.722, the cost of administering ORS 475A.210 to 475A.722;
22 and

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

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

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

1 **“SECTION 37.** ORS 475A.338 is amended to read:
2 “475A.338. (1)(a) As used in this subsection, ‘board’ means:
3 **“(A) The Occupational Therapy Licensing Board;**
4 “[(A)] **(B)** The Oregon Board of Licensed Professional Counselors and
5 Therapists;
6 “[(B)] **(C)** The Oregon Board of Naturopathic Medicine;
7 **“(D) The Oregon Board of Physical Therapy;**
8 “[(C)] **(E)** The Oregon Board of Psychology;
9 “[(D)] **(F)** The Oregon Medical Board;
10 “[(E)] **(G)** The Oregon State Board of Nursing;
11 “[(F)] **(H)** The State Board of Licensed Social Workers; and
12 “[(G)] **(I)** The State Board of Pharmacy.
13 “(b) A person who is licensed or otherwise authorized by a board to pro-
14 vide health care or behavioral health care services and who holds a license
15 under ORS 475A.325 may, in accordance with the provisions of ORS 475A.210
16 to 475A.722 and rules adopted under ORS 475A.210 to 475A.722:
17 “(A) Conduct preparation sessions and integration sessions with clients
18 in addition to and while providing health care or behavioral health care
19 services.
20 “(B) Conduct administration sessions with clients, so long as the person
21 does not provide health care or behavioral health care services while pro-
22 viding psilocybin services.
23 “(2) A health care provider, as defined in ORS 127.505, may not be subject
24 to a civil penalty or other disciplinary action by the state agency that reg-
25 ulates the health care provider for:
26 “(a) Discussing with a client or patient, as a treatment option, psilocybin
27 services provided by a psilocybin service facilitator that holds a license is-
28 sued under ORS 475A.325 at a psilocybin service center for which a license
29 is issued under ORS 475A.305; or
30 “(b) If the health care provider holds a license issued under ORS 475A.325,

1 providing psilocybin services in accordance with the provisions of ORS
2 475A.210 to 475A.722 and rules adopted under ORS 475A.210 to 475A.722, so
3 long as the health care provider does not provide health care services while
4 providing psilocybin services.

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

6 “475A.372. (1) As used in this section, ‘adverse behavioral reaction’ and
7 ‘adverse medical reaction’ have the meanings given those terms by rule by
8 the Oregon Health Authority.

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

11 “(a) Collect and maintain the following information, in addition to the
12 information required to complete a client information form described in ORS
13 475A.350:

14 “(A) The race, ethnicity, preferred spoken and written languages, disabil-
15 ity status, sexual orientation, gender identity, income, age, veteran status
16 and county of residence of each client; and

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

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

21 “(A) The number of clients served;

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

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

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

28 “(E) The number and severity of:

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

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

3 “(F) Any additional information required by the authority by rule as de-
4 scribed in subsection (7) of this section; and

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

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

9 “(B) The average number of clients participating in each group adminis-
10 tration session; [*and*]

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

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

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

18 “(4) Subject to subsection (3) of this section, a psilocybin service center
19 operator shall aggregate and submit, in a manner that protects the per-
20 sonally identifiable information of a client or individual from whom infor-
21 mation is collected, to the authority on a quarterly basis the information
22 described in subsection (2) of this section. The authority may exempt from
23 the submission requirement information that the authority determines cannot
24 be adequately deidentified.

25 “(5) The authority shall submit the information received under subsection
26 (4) of this section to the Oregon Health and Science University for the pur-
27 pose of enabling the evaluation of outcomes of psilocybin services provided
28 under ORS 475A.210 to 475A.722.

29 “(6)(a) Except as otherwise required by law, the information collected,
30 maintained and reported under this section is exempt from disclosure under

1 ORS 192.311 to 192.478.

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

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

10 **“SECTION 39. (1) The amendments to ORS 475A.325, 475A.338 and**
11 **475A.372 by sections 36 to 38 of this 2026 Act become operative on**
12 **January 1, 2027.**

13 **“(2) The Oregon Health Authority, the Occupational Therapy Li-**
14 **censing Board and the Oregon Board of Physical Therapy may take**
15 **any action before the operative date specified in subsection (1) of this**
16 **section that is necessary to enable the authority and the boards to**
17 **exercise, on and after the operative date specified in subsection (1) of**
18 **this section, all of the duties, functions and powers conferred on the**
19 **authority and the boards by the amendments to ORS 475A.325, 475A.338**
20 **and 475A.372 by sections 36 to 38 of this 2026 Act.**

21

22 **“NATUROPATHIC PHYSICIANS**

23

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

25 “685.100. (1) Upon approval of an application for a licensure, the Oregon
26 Board of Naturopathic Medicine shall issue a license certificate that shall
27 be displayed at all times in the office of the person to whom it was issued
28 while the license is active.

29 “(2) A person holding an active license issued under this chapter may
30 apply to the board for license renewal. A completed renewal application

1 consists of:

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

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

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

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

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

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

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

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

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

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

10 “(a) An initial license.

11 “(b) Examination.

12 “(c) Renewal of an active license.

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

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

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

16 “(g) A duplicate license.

17 “(h) A wall certificate.

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

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

26 “**SECTION 41.** ORS 685.102 is amended to read:

27 “685.102. (1) Except as provided in subsections (2) and (5) of this section,
28 each person holding a license under this chapter shall submit annually by
29 December 31, evidence satisfactory to the Oregon Board of Naturopathic
30 Medicine of successful completion of an approved program of continuing ed-

1 ucation of at least 25 hours in naturopathic medicine, completed in the cal-
2 endar year preceding the date on which the evidence is submitted, and
3 completion during the renewal period, or documentation of completion within
4 the previous 36 months, of:

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

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

10 “(2) The board may exempt any person holding a license under this
11 chapter from the requirements of subsection (1) of this section upon appli-
12 cation showing evidence satisfactory to the board of inability to comply with
13 the requirements because of physical or mental condition or because of other
14 unusual or extenuating circumstances. However, a person may not be ex-
15 empted from the requirements of subsection (1) of this section more than
16 once in any five-year period.

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

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

26 “(5) A person whose license is in inactive status must submit by December
27 31 of each year evidence satisfactory to the board of completion of 10 hours
28 of approved continuing education in the calendar year preceding the date on
29 which the evidence is submitted.

30 “(6) Notwithstanding subsections (1), (2) and (5) of this section, in the

1 case of an applicant under ORS 685.100 (6)(b) for reactivation of an inactive
2 license, the continuing education requirement for reactivation shall be set
3 by rule of the board.

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

6 **“(2) The Oregon Board of Naturopathic Medicine may take any**
7 **action before the operative date specified in subsection (1) of this sec-**
8 **tion that is necessary to enable the board to exercise, on and after the**
9 **operative date specified in subsection (1) of this section, all of the du-**
10 **ties, functions and powers conferred on the board by the amendments**
11 **to ORS 685.100 and 685.102 by sections 40 and 41 of this 2026 Act.**

12

13 **“WORKERS’ COMPENSATION RECLASSIFICATION OF**
14 **PHYSICIAN ASSOCIATES AND NURSE PRACTITIONERS**

15

16 **“SECTION 43.** ORS 656.005 is amended to read:

17 “656.005. (1) ‘Average weekly wage’ means the Oregon average weekly
18 wage in covered employment, as determined by the Employment Department,
19 for the last quarter of the calendar year preceding the fiscal year in which
20 the injury occurred.

21 “(2)(a) ‘Beneficiary’ means an injured worker, and the spouse in a mar-
22 riage, child or dependent of a worker, who is entitled to receive payments
23 under this chapter.

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

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

27 “(4) ‘Carrier-insured employer’ means an employer who provides workers’
28 compensation coverage with the State Accident Insurance Fund Corporation
29 or an insurer authorized under ORS chapter 731 to transact workers’ com-
30 pensation insurance in this state.

1 “(5) ‘Child’ means a child of an injured worker, including:
2 “(a) A posthumous child;
3 “(b) A child legally adopted before the injury;
4 “(c) A child toward whom the worker stands in loco parentis;
5 “(d) A child born out of wedlock;
6 “(e) A stepchild, if the stepchild was, at the time of the injury, a member
7 of the worker’s family and substantially dependent upon the worker for
8 support; and
9 “(f) A child of any age who was incapacitated at the time of the accident
10 and thereafter remains incapacitated and substantially dependent on the
11 worker for support.
12 “(6) ‘Claim’ means a written request for compensation from a subject
13 worker or someone on the worker’s behalf, or any compensable injury of
14 which a subject employer has notice or knowledge.
15 “(7)(a) A ‘compensable injury’ is an accidental injury, or accidental injury
16 to prosthetic appliances, arising out of and in the course of employment re-
17 quiring medical services or resulting in disability or death. An injury is ac-
18 cidental if the result is an accident, whether or not due to accidental means,
19 if it is established by medical evidence supported by objective findings, sub-
20 ject to the following limitations:
21 “(A) An injury or disease is not compensable as a consequence of a
22 compensable injury unless the compensable injury is the major contributing
23 cause of the consequential condition.
24 “(B) If an otherwise compensable injury combines at any time with a
25 preexisting condition to cause or prolong disability or a need for treatment,
26 the combined condition is compensable only if, so long as and to the extent
27 that the otherwise compensable injury is the major contributing cause of the
28 disability of the combined condition or the major contributing cause of the
29 need for treatment of the combined condition.
30 “(b) ‘Compensable injury’ does not include:

1 “(A) Injury to any active participant in assaults or combats that are not
2 connected to the job assignment and that amount to a deviation from cus-
3 tomary duties;

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

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

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

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

18 “(8) ‘Compensation’ includes all benefits, including medical services, pro-
19 vided for a compensable injury to a subject worker or the worker’s benefi-
20 ciaries by an insurer or self-insured employer pursuant to this chapter.

21 “(9) ‘Department’ means the Department of Consumer and Business Ser-
22 vices.

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

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

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

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

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

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

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

7 “(12)(a) [*‘Doctor’ or ‘physician’*] **‘Doctor,’ ‘physician,’ ‘nurse practi-**
8 **tioner’ or ‘physician associate’** means a person duly licensed to practice
9 one or more of the healing arts in any country or in any state, territory or
10 possession of the United States within the limits of the license of the
11 licensee.

12 “(b) Except as otherwise provided for workers subject to a managed care
13 contract, ‘attending physician’ means a doctor, physician, **nurse practi-**
14 **tioner** or physician associate who is primarily responsible for the treatment
15 of a worker’s compensable injury and who is:

16 “[*(A) A physician licensed under ORS 677.100 to 677.228 by the Oregon*
17 *Medical Board, or a podiatric physician and surgeon licensed under ORS*
18 *677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial*
19 *surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
20 *doctor in any country or in any state, territory or possession of the United*
21 *States;*]

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

25 “(ii) **A podiatric physician and surgeon licensed under ORS 677.805**
26 **to 677.840 by the Oregon Medical Board or a similarly licensed physi-**
27 **cian and surgeon in any country or in any state, territory or pos-**
28 **session of the United States;**

29 “(iii) **An oral and maxillofacial surgeon licensed by the Oregon**
30 **Board of Dentistry or a similarly licensed surgeon in any country or**

1 **in any state, territory or possession of the United States;**

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

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

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

12 **“(i) Doctor or physician licensed by the State Board of Chiropractic Ex-**
13 **aminers for the State of Oregon under ORS chapter 684 or a similarly li-**
14 **censed doctor or physician in any country or in any state, territory or**
15 **possession of the United States; or**

16 **“(ii) Doctor of naturopathy or naturopathic physician licensed by the**
17 **Oregon Board of Naturopathic Medicine under ORS chapter 685 or a simi-**
18 **larly licensed doctor or physician in any country or in any state, territory**
19 **or possession of the United States.]; or]**

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

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

28 **“(d) ‘Consulting physician’ means a doctor or physician who examines a**
29 **worker or the worker’s medical record to advise the attending physician [*or***
30 ***nurse practitioner authorized to provide compensable medical services under***

1 *ORS 656.245*] regarding treatment of a worker’s compensable injury.

2 “(13)(a) ‘Employer’ means any person, including receiver, administrator,
3 executor or trustee, and the state, state agencies, counties, municipal corpo-
4 rations, school districts and other public corporations or political subdi-
5 visions, that contracts to pay a remuneration for the services of any worker.

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

9 “(c) As used in paragraph (b) of this subsection, ‘temporary service pro-
10 vider’ has the meaning given that term in *ORS 656.850*.

11 “(d) For the purposes of this chapter, ‘subject employer’ means an em-
12 ployer that is subject to this chapter as provided in *ORS 656.023*.

13 “(14) ‘Insurer’ means the State Accident Insurance Fund Corporation or
14 an insurer authorized under *ORS chapter 731* to transact workers’ compen-
15 sation insurance in this state or an assigned claims agent selected by the
16 director under *ORS 656.054*.

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

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

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

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

25 “(19) ‘Objective findings’ in support of medical evidence are verifiable
26 indications of injury or disease that may include, but are not limited to,
27 range of motion, atrophy, muscle strength and palpable muscle spasm. ‘Ob-
28 jective findings’ does not include physical findings or subjective responses
29 to physical examinations that are not reproducible, measurable or observa-
30 ble.

1 “(20) ‘Palliative care’ means medical service rendered to reduce or mod-
2 erate temporarily the intensity of an otherwise stable medical condition, but
3 does not include those medical services rendered to diagnose, heal or per-
4 manently alleviate or eliminate a medical condition.

5 “(21) ‘Party’ means a claimant for compensation, the employer of the in-
6 jured worker at the time of injury and the insurer, if any, of the employer.

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

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

21 “(24)(a) ‘Preexisting condition’ means, for all industrial injury claims, any
22 injury, disease, congenital abnormality, personality disorder or similar con-
23 dition that contributes to disability or need for treatment, provided that:

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

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

30 “(ii) In claims for a new medical condition, the diagnosis or treatment

1 precedes the onset of the new medical condition; or

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

4 “(b) ‘Preexisting condition’ means, for all occupational disease claims, any
5 injury, disease, congenital abnormality, personality disorder or similar con-
6 dition that contributes to disability or need for treatment and that precedes
7 the onset of the claimed occupational disease, or precedes a claim for wors-
8 ening in such claims pursuant to ORS 656.273 or 656.278.

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

12 “(25) ‘Self-insured employer’ means an employer or group of employers
13 certified under ORS 656.430 as meeting the qualifications set out by ORS
14 656.407.

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

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

28 “(28)(a) ‘Worker’ means any person, other than an independent contractor,
29 who engages to furnish services for a remuneration, including a minor
30 whether lawfully or unlawfully employed and salaried, elected and appointed

1 officials of the state, state agencies, counties, cities, school districts and
2 other public corporations, but does not include any person whose services
3 are performed as an adult in custody or ward of a state institution or as part
4 of the eligibility requirements for a general or public assistance grant.

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

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

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

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

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

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

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

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

25 “(4) ‘Carrier-insured employer’ means an employer who provides workers’
26 compensation coverage with the State Accident Insurance Fund Corporation
27 or an insurer authorized under ORS chapter 731 to transact workers’ com-
28 pensation insurance in this state.

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

30 “(a) A posthumous child;

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

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

3 “(d) A child born out of wedlock;

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

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

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

13 “(7)(a) A ‘compensable injury’ is an accidental injury, or accidental injury
14 to prosthetic appliances, arising out of and in the course of employment re-
15 quiring medical services or resulting in disability or death. An injury is ac-
16 cidental if the result is an accident, whether or not due to accidental means,
17 if it is established by medical evidence supported by objective findings, sub-
18 ject to the following limitations:

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

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

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

29 “(A) Injury to any active participant in assaults or combats that are not
30 connected to the job assignment and that amount to a deviation from cus-

1 tomary duties;

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

5 “(C) Injury the major contributing cause of which is demonstrated to be
6 by a preponderance of the evidence the injured worker’s consumption of al-
7 coholic beverages or cannabis or the unlawful consumption of any controlled
8 substance, unless the employer permitted, encouraged or had actual knowl-
9 edge of such consumption.

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

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

16 “(8) ‘Compensation’ includes all benefits, including medical services, pro-
17 vided for a compensable injury to a subject worker or the worker’s benefi-
18 ciaries by an insurer or self-insured employer pursuant to this chapter.

19 “(9) ‘Department’ means the Department of Consumer and Business Ser-
20 vices.

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

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

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

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

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

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

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

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

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

14 “[*(A) A physician licensed under ORS 677.100 to 677.228 by the Oregon*
15 *Medical Board, or a podiatric physician and surgeon licensed under ORS*
16 *677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial*
17 *surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
18 *doctor in any country or in any state, territory or possession of the United*
19 *States;*]

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

23 “(ii) **A podiatric physician and surgeon licensed under ORS 677.805**
24 **to 677.840 by the Oregon Medical Board or a similarly licensed physi-**
25 **cian and surgeon in any country or in any state, territory or pos-**
26 **session of the United States;**

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

30 “(iv) **A nurse practitioner licensed under ORS 678.375 to 678.390 or**

1 **a similarly licensed nurse practitioner in any country or in any state,**
2 **territory or possession of the United States; or**

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

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

10 **“(i) Doctor or physician licensed by the State Board of Chiropractic Ex-**
11 **aminers for the State of Oregon under ORS chapter 684 or a similarly li-**
12 **censed doctor or physician in any country or in any state, territory or**
13 **possession of the United States; or**

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

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

22 **“(c) Except as otherwise provided for workers subject to a managed care**
23 **contract, ‘attending physician’ does not include a physician who provides**
24 **care in a hospital emergency room and refers the injured worker to a pri-**
25 **mary care physician for follow-up care and treatment.**

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

30 **“(13)(a) ‘Employer’ means any person, including receiver, administrator,**

1 executor or trustee, and the state, state agencies, counties, municipal corpo-
2 rations, school districts and other public corporations or political subdi-
3 visions, that contracts to pay a remuneration for the services of any worker.

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

7 “(c) As used in paragraph (b) of this subsection, ‘temporary service pro-
8 vider’ has the meaning given that term in ORS 656.849.

9 “(d) For the purposes of this chapter, ‘subject employer’ means an em-
10 ployer that is subject to this chapter as provided in ORS 656.023.

11 “(14) ‘Insurer’ means the State Accident Insurance Fund Corporation or
12 an insurer authorized under ORS chapter 731 to transact workers’ compen-
13 sation insurance in this state or an assigned claims agent selected by the
14 director under ORS 656.054.

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

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

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

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

23 “(19) ‘Objective findings’ in support of medical evidence are verifiable
24 indications of injury or disease that may include, but are not limited to,
25 range of motion, atrophy, muscle strength and palpable muscle spasm. ‘Ob-
26 jective findings’ does not include physical findings or subjective responses
27 to physical examinations that are not reproducible, measurable or observa-
28 ble.

29 “(20) ‘Palliative care’ means medical service rendered to reduce or mod-
30 erate temporarily the intensity of an otherwise stable medical condition, but

1 does not include those medical services rendered to diagnose, heal or per-
2 manently alleviate or eliminate a medical condition.

3 “(21) ‘Party’ means a claimant for compensation, the employer of the in-
4 jured worker at the time of injury and the insurer, if any, of the employer.

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

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

19 “(24)(a) ‘Preexisting condition’ means, for all industrial injury claims, any
20 injury, disease, congenital abnormality, personality disorder or similar con-
21 dition that contributes to disability or need for treatment, provided that:

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

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

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

30 “(iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the

1 diagnosis or treatment precedes the onset of the worsened condition.

2 “(b) ‘Preexisting condition’ means, for all occupational disease claims, any
3 injury, disease, congenital abnormality, personality disorder or similar con-
4 dition that contributes to disability or need for treatment and that precedes
5 the onset of the claimed occupational disease, or precedes a claim for wors-
6 ening in such claims pursuant to ORS 656.273 or 656.278.

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

10 “(25) ‘Self-insured employer’ means an employer or group of employers
11 certified under ORS 656.430 as meeting the qualifications set out by ORS
12 656.407.

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

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

26 “(28)(a) ‘Worker’ means any person, other than an independent contractor,
27 who engages to furnish services for a remuneration, including a minor
28 whether lawfully or unlawfully employed and salaried, elected and appointed
29 officials of the state, state agencies, counties, cities, school districts and
30 other public corporations, but does not include any person whose services

1 are performed as an adult in custody or ward of a state institution or as part
2 of the eligibility requirements for a general or public assistance grant.

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

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

9 “(29) ‘Independent contractor’ has the meaning given that term in ORS
10 670.600.

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

12 “656.214. (1) As used in this section:

13 “(a) ‘Impairment’ means the loss of use or function of a body part or
14 system due to the compensable industrial injury or occupational disease de-
15 termined in accordance with the standards provided under ORS 656.726, ex-
16 pressed as a percentage of the whole person.

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

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

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

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

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

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

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

28 “(a) If the worker has been released to regular work by the attending
29 physician [*or nurse practitioner authorized to provide compensable medical*
30 *services under ORS 656.245*] or has returned to regular work [*at the job held*

1 *at the time of injury*], the award shall be for impairment only. Impairment
2 shall be determined in accordance with the standards provided by the Di-
3 rector of the Department of Consumer and Business Services pursuant to
4 ORS 656.726 (4). Impairment benefits are determined by multiplying the
5 impairment value times 100 times the average weekly wage as defined by
6 ORS 656.005.

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

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

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

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

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

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

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

30 “(f) For partial or complete loss of hearing in one ear, that proportion

1 of 19 percent which the loss bears to normal monaural hearing.

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

11 “(h) For partial or complete loss of vision of one eye, that proportion of
12 31 percent which the loss of monocular vision bears to normal monocular
13 vision. For the purposes of this paragraph, the term ‘normal monocular vi-
14 sion’ shall be considered as Snellen 20/20 for distance and Snellen 14/14 for
15 near vision with full sensory field.

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

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

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

29 “(4) The loss of one phalange of a thumb, including the adjacent
30 epiphyseal region of the proximal phalange, is considered equal to the loss

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

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

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

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

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

28 “(b) Compensable medical services shall include medical, surgical, hospi-
29 tal, nursing, ambulances and other related services, and drugs, medicine,
30 crutches and prosthetic appliances, braces and supports and where necessary,

1 physical restorative services. A pharmacist or dispensing physician shall
2 dispense generic drugs to the worker in accordance with ORS 689.515. The
3 duty to provide such medical services continues for the life of the worker.

4 “(c) Notwithstanding any other provision of this chapter, medical services
5 after the worker’s condition is medically stationary are not compensable ex-
6 cept for the following:

7 “(A) Services provided to a worker who has been determined to be per-
8 manently and totally disabled.

9 “(B) Prescription medications.

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

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

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

15 “(F) Services provided pursuant to an accepted claim for aggravation un-
16 der ORS 656.273.

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

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

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

21 “(J) With the approval of the insurer or self-insured employer, palliative
22 care that the worker’s attending physician referred to in ORS 656.005
23 (12)(b)(A) prescribes and that is necessary to enable the worker to continue
24 current employment or a vocational training program. If the insurer or self-
25 insured employer does not approve, the attending physician or the worker
26 may request approval from the Director of the Department of Consumer and
27 Business Services for such treatment. The director may order a medical re-
28 view by a physician or panel of physicians pursuant to ORS 656.327 (3) to
29 aid in the review of such treatment. The decision of the director is subject
30 to review under ORS 656.704.

1 “(K) With the approval of the director, curative care arising from a gen-
2 erally recognized, nonexperimental advance in medical science since the
3 worker’s claim was closed that is highly likely to improve the worker’s
4 condition and that is otherwise justified by the circumstances of the claim.
5 The decision of the director is subject to review under ORS 656.704.

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

8 “(d) When the medically stationary date in a disabling claim is estab-
9 lished by the insurer or self-insured employer and is not based on the
10 findings of the attending physician, the insurer or self-insured employer is
11 responsible for reimbursement to affected medical service providers for oth-
12 erwise compensable services rendered until the insurer or self-insured em-
13 ployer provides written notice to the attending physician of the worker’s
14 medically stationary status.

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

24 “(2)(a) The worker may choose an attending [*doctor, physician or nurse*
25 *practitioner*] **physician** within the State of Oregon. The worker may choose
26 the initial attending physician [*or nurse practitioner*] and may subsequently
27 change attending physician [*or nurse practitioner*] two times without ap-
28 proval from the director. If the worker thereafter selects another attending
29 physician [*or nurse practitioner*], the insurer or self-insured employer may
30 require the director’s approval of the selection. The decision of the director

1 is subject to review under ORS 656.704. The worker also may choose an at-
2 tending doctor or physician in another country or in any state or territory
3 or possession of the United States with the prior approval of the insurer or
4 self-insured employer.

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

7 “(A) A medical service provider who is not qualified to be an attending
8 physician may provide compensable medical service to an injured worker for
9 a period of 30 days from the date of the first visit on the initial claim or for
10 12 visits, whichever first occurs, without the authorization of an attending
11 physician. Thereafter, medical service provided to an injured worker without
12 the written authorization of an attending physician is not compensable.

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

21 “(C) Except as otherwise provided in this chapter, only a physician qual-
22 ified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i)
23 who is serving as the attending physician at the time of claim closure may
24 make findings regarding the worker’s impairment for the purpose of evalu-
25 ating the worker’s disability.

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

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

3 “(ii) May authorize the payment of temporary disability benefits for a pe-
4 riod not to exceed 180 days from the date of the first visit on the initial claim;
5 and]

6 “(iii) When an injured worker treating with a nurse practitioner or phy-
7 sician associate authorized to provide compensable services under this section
8 becomes medically stationary within the 180-day period in which the nurse
9 practitioner or physician associate is authorized to treat the injured worker,
10 shall refer the injured worker to a physician qualified to be an attending
11 physician as defined in ORS 656.005 for the purpose of making findings re-
12 garding the worker’s impairment for the purpose of evaluating the worker’s
13 disability. If a worker returns to the nurse practitioner or physician associate
14 after initial claim closure for evaluation of a possible worsening of the
15 worker’s condition, the nurse practitioner or physician associate shall refer the
16 worker to an attending physician and the insurer shall compensate the nurse
17 practitioner or physician associate for the examination performed.]

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

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

28 “(a) Those workers who are subject to the contract shall receive medical
29 services in the manner prescribed in the contract. Workers subject to the
30 contract include those who are receiving medical treatment for an accepted

1 compensable injury or occupational disease, regardless of the date of injury
2 or medically stationary status, on or after the effective date of the contract.
3 If the managed care organization determines that the change in provider
4 would be medically detrimental to the worker, the worker shall not become
5 subject to the contract until the worker is found to be medically stationary,
6 the worker changes physicians [*or nurse practitioners*], or the managed care
7 organization determines that the change in provider is no longer medically
8 detrimental, whichever event first occurs. A worker becomes subject to the
9 contract upon the worker's receipt of actual notice of the worker's enroll-
10 ment in the managed care organization, or upon the third day after the no-
11 tice was sent by regular mail by the insurer or self-insured employer,
12 whichever event first occurs. A worker shall not be subject to a contract
13 after it expires or terminates without renewal. A worker may continue to
14 treat with the attending physician [*or nurse practitioner*] authorized to pro-
15 vide compensable medical services under this section under an expired or
16 terminated managed care organization contract if the **attending** physician
17 [*or nurse practitioner*] agrees to comply with the rules, terms and conditions
18 regarding services performed under any subsequent managed care organiza-
19 tion contract to which the worker is subject. A worker shall not be subject
20 to a contract if the worker's primary residence is more than 100 miles out-
21 side the managed care organization's certified geographical area. Each such
22 contract must comply with the certification standards provided in ORS
23 656.260. However, a worker may receive immediate emergency medical treat-
24 ment that is compensable from a medical service provider who is not a
25 member of the managed care organization. Insurers or self-insured employers
26 who contract with a managed care organization for medical services shall
27 give notice to the workers of eligible medical service providers and such
28 other information regarding the contract and manner of receiving medical
29 services as the director may prescribe. Notwithstanding any provision of law
30 or rule to the contrary, a worker of a noncomplying employer is considered

1 to be subject to a contract between the State Accident Insurance Fund Cor-
2 poration as a processing agent or the assigned claims agent and a managed
3 care organization.

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

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

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

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

30 “(5)(a) A nurse practitioner[,] or a physician associate described in ORS

1 656.005 [(12)(b)(C),] (12)(b)(A)(iv) or (v) who is not a member of the managed
2 care organization is authorized to provide the same level of services as a
3 primary care physician as established by ORS 656.260 (4) if the nurse prac-
4 titioner or physician associate:

5 “(A) Maintains the worker’s medical records;

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

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

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

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

14 “[i)] (A) Provide medical treatment to the worker if the treatment is
15 determined to be medically appropriate according to the service utilization
16 review process of the managed care organization; and

17 “[ii)] (B) Authorize temporary disability payments [*as provided in sub-*
18 *section (2)(b)(D) of this section*].

19 “[B) *The managed care organization may also authorize the nurse practi-*
20 *tioner or physician associate to provide medical services and authorize tempo-*
21 *rary disability payments beyond the periods established in subsection (2)(b)(D)*
22 *of this section.*]

23 “(6) Subject to the provisions of ORS 656.704, if a claim for medical ser-
24 vices is disapproved, the injured worker, insurer or self-insured employer
25 may request administrative review by the director pursuant to ORS 656.260
26 or 656.327.

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

28 “656.250. A physical therapist [*shall*] **may** not provide compensable ser-
29 vices to injured workers governed by this chapter except as allowed by a
30 governing managed care organization contract or as authorized by the

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

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

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

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

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

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

24 "(d) Such other reporting requirements as the director may deem neces-
25 sary to insure that payments of compensation be prompt and that all inter-
26 ested parties be given information necessary to the prompt determination of
27 claims.

28 "(e) Requiring insurers and self-insured employers to audit billings for all
29 medical services, including hospital services.

30 "(2) The attending physician [*or nurse practitioner authorized to provide*

1 *compensable medical services under ORS 656.245*] shall do the following:

2 “(a) Cooperate with the insurer or self-insured employer to expedite di-
3 agnostic and treatment procedures and with efforts to return injured workers
4 to appropriate work.

5 “(b) Advise the insurer or self-insured employer of the anticipated date
6 for release of the injured worker to return to employment, the anticipated
7 date that the worker will be medically stationary, and the next appointment
8 date. Except when the attending physician [*or nurse practitioner authorized*
9 *to provide compensable medical services under ORS 656.245*] has previously
10 indicated that temporary disability will not exceed 14 days, the insurer or
11 self-insured employer may request a medical report every 15 days, and the
12 attending physician [*or nurse practitioner*] shall forward such reports.

13 “(c) Advise the insurer or self-insured employer within five days of the
14 date the injured worker is released to return to work. Under no circum-
15 stances shall the physician [*or nurse practitioner authorized to provide*
16 *compensable medical services under ORS 656.245*] notify the insurer or em-
17 ployer of the worker’s release to return to work without notifying the worker
18 at the same time.

19 “(d) After a claim has been closed, advise the insurer or self-insured em-
20 ployer within five days after the treatment is resumed or the reopening of
21 a claim is recommended. The attending physician under this paragraph need
22 not be the same attending physician who released the worker when the claim
23 was closed.

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

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

30 “(5) Whenever an injured worker changes attending [*physicians or nurse*

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

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

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

14 “656.262. (1) Processing of claims and providing compensation for a
15 worker shall be the responsibility of the insurer or self-insured employer.
16 All employers shall assist their insurers in processing claims as required in
17 this chapter.

18 “(2) The compensation due under this chapter shall be paid periodically,
19 promptly and directly to the person entitled thereto upon the employer’s re-
20 ceiving notice or knowledge of a claim, except where the right to compen-
21 sation is denied by the insurer or self-insured employer.

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

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

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

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

30 “(D) The name and address of any health insurance provider for the in-

1 injured worker.

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

3 “(b) Failure to so report subjects the offending employer to a charge for
4 reimbursing the insurer for any penalty the insurer is required to pay under
5 subsection (11) of this section because of such failure. As used in this sub-
6 section, ‘health insurance’ has the meaning for that term provided in ORS
7 731.162.

8 “(4)(a) The first installment of temporary disability compensation shall
9 be paid no later than the 14th day after the subject employer has notice or
10 knowledge of the claim and of the worker’s disability, if the attending phy-
11 sician [*or nurse practitioner authorized to provide compensable medical ser-*
12 *vices under ORS 656.245*] authorizes the payment of temporary disability
13 compensation. Thereafter, temporary disability compensation shall be paid
14 at least once each two weeks, except where the Director of the Department
15 of Consumer and Business Services determines that payment in installments
16 should be made at some other interval. The director may by rule convert
17 monthly benefit schedules to weekly or other periodic schedules.

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

24 “(c) Notwithstanding any other provision of this chapter, when the holder
25 of a public office is injured in the course and scope of that public office, full
26 official salary paid to the holder of that public office shall be deemed timely
27 payment of temporary disability payments pursuant to ORS 656.210 and
28 656.212 during the time the wage payments are made. As used in this sub-
29 section, ‘public office’ has the meaning for that term provided in ORS
30 260.005.

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

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

18 “(f) If the insurer or self-insured employer has requested and failed to
19 receive from the worker’s attending physician [*or nurse practitioner author-*
20 *ized to provide compensable medical services under ORS 656.245*] verification
21 of the worker’s inability to work resulting from the claimed injury or dis-
22 ease, medical services provided by the attending physician [*or nurse practi-*
23 *tioner*] are not compensable until the attending physician [*or nurse*
24 *practitioner*] submits such verification.

25 “(g)(A) Temporary disability compensation is not due and payable pursu-
26 ant to ORS 656.268 after the worker’s attending physician [*or nurse practi-*
27 *tioner authorized to provide compensable medical services under ORS*
28 *656.245*] ceases to authorize temporary disability or for any period of time
29 not authorized by the attending physician [*or nurse practitioner*]. No au-
30 thorization of temporary disability compensation by the attending physician

1 [or nurse practitioner] under ORS 656.268 shall be effective to retroactively
2 authorize the payment of temporary disability more than 45 days prior to its
3 issuance.

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

5 “(i) During periods in which there is a denial under the jurisdiction of
6 the Workers’ Compensation Board that affects the worker’s ability to obtain
7 authorization of temporary disability;

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

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

13 “(h) The worker’s disability may be authorized only by [a person
14 described] **an attending physician as defined** in ORS 656.005 (12)(b)(B), or
15 **a person described in ORS 656.245**, for the period of time permitted by
16 those sections. The insurer or self-insured employer may unilaterally suspend
17 payment of temporary disability benefits to the worker at the expiration of
18 the period until temporary disability is reauthorized by [an] **the** attending
19 physician [or nurse practitioner authorized to provide compensable medical
20 services under ORS 656.245].

21 “(i) The insurer or self-insured employer may unilaterally suspend pay-
22 ment of all compensation to a worker enrolled in a managed care organiza-
23 tion if the worker continues to seek care from an attending physician [or
24 nurse practitioner authorized to provide compensable medical services under
25 ORS 656.245] that is not authorized by the managed care organization more
26 than seven days after the mailing of notice by the insurer or self-insured
27 employer.

28 “(j)(A) The insurer or self-insured employer may not end temporary disa-
29 bility benefits until written notice has been mailed or delivered to the
30 worker and the worker’s attorney, if the worker is represented. The notice

1 must state the reason that temporary disability benefits are no longer due
2 and payable.

3 “(B) The worker’s attending physician [*or nurse practitioner*] may
4 retroactively authorize temporary disability for up to 45 days prior to the
5 date of the notice.

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

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

25 “(b) To establish the maximum amount an employer may pay for medical
26 services for nondisabling claims under paragraph (a) of this subsection, the
27 director shall use \$1,500 as the base compensation amount and shall adjust
28 the base compensation amount annually to reflect changes in the United
29 States City Average Consumer Price Index for All Urban Consumers for
30 Medical Care for July of each year as published by the Bureau of Labor

1 Statistics of the United States Department of Labor. The adjustment shall
2 be rounded to the nearest multiple of \$100.

3 “(c) The adjusted amount established under paragraph (b) of this sub-
4 section shall be effective on January 1 following the establishment of the
5 amount and shall apply to claims with a date of injury on or after the ef-
6 fective date of the adjusted amount.

7 “(6)(a) Written notice of acceptance or denial of the claim shall be fur-
8 nished to the claimant by the insurer or self-insured employer within 60 days
9 after the employer has notice or knowledge of the claim. Once the claim is
10 accepted, the insurer or self-insured employer shall not revoke acceptance
11 except as provided in this section. The insurer or self-insured employer may
12 revoke acceptance and issue a denial at any time when the denial is for
13 fraud, misrepresentation or other illegal activity by the worker. If the
14 worker requests a hearing on any revocation of acceptance and denial al-
15 leging fraud, misrepresentation or other illegal activity, the insurer or self-
16 insured employer has the burden of proving, by a preponderance of the
17 evidence, such fraud, misrepresentation or other illegal activity. Upon such
18 proof, the worker then has the burden of proving, by a preponderance of the
19 evidence, the compensability of the claim. If the insurer or self-insured em-
20 ployer accepts a claim in good faith, in a case not involving fraud, misrep-
21 resentation or other illegal activity by the worker, and later obtains evidence
22 that the claim is not compensable or evidence that the insurer or self-insured
23 employer is not responsible for the claim, the insurer or self-insured em-
24 ployer may revoke the claim acceptance and issue a formal notice of claim
25 denial, if such revocation of acceptance and denial is issued no later than
26 two years after the date of the initial acceptance. If the worker requests a
27 hearing on such revocation of acceptance and denial, the insurer or self-
28 insured employer must prove, by a preponderance of the evidence, that the
29 claim is not compensable or that the insurer or self-insured employer is not
30 responsible for the claim. Notwithstanding any other provision of this chap-

1 ter, if a denial of a previously accepted claim is set aside by an Adminis-
2 trative Law Judge, the Workers' Compensation Board or the court,
3 temporary total disability benefits are payable from the date any such bene-
4 fits were terminated under the denial. Except as provided in ORS 656.247,
5 pending acceptance or denial of a claim, compensation payable to a claimant
6 does not include the costs of medical benefits or funeral expenses. The
7 insurer shall also furnish the employer a copy of the notice of acceptance.

8 “(b) The notice of acceptance shall:

9 “(A) Specify what conditions are compensable.

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

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

16 “(D) Inform the claimant of employment reinstatement rights and re-
17 sponsibilities under ORS chapter 659A.

18 “(E) Inform the claimant of assistance available to employers and workers
19 from the Reemployment Assistance Program under ORS 656.622.

20 “(F) Be modified by the insurer or self-insured employer from time to time
21 as medical or other information changes a previously issued notice of ac-
22 ceptance.

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

29 “(d) An injured worker who believes that a condition has been incorrectly
30 omitted from a notice of acceptance, or that the notice is otherwise deficient,

1 first must communicate in writing to the insurer or self-insured employer the
2 worker's objections to the notice pursuant to ORS 656.267. The insurer or
3 self-insured employer has 60 days from receipt of the communication from the
4 worker to revise the notice or to make other written clarification in re-
5 sponse. A worker who fails to comply with the communication requirements
6 of this paragraph or ORS 656.267 may not allege at any hearing or other
7 proceeding on the claim a de facto denial of a condition based on information
8 in the notice of acceptance from the insurer or self-insured employer. Not-
9 withstanding any other provision of this chapter, the worker may initiate
10 objection to the notice of acceptance at any time.

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

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

24 “(c) When an insurer or self-insured employer determines that the claim
25 qualifies for claim closure, the insurer or self-insured employer shall issue
26 at claim closure an updated notice of acceptance that specifies which condi-
27 tions are compensable. The procedures specified in subsection (6)(d) of this
28 section apply to this notice. Any objection to the updated notice or appeal
29 of denied conditions shall not delay claim closure pursuant to ORS 656.268.
30 If a condition is found compensable after claim closure, the insurer or self-

1 insured employer shall reopen the claim for processing regarding that con-
2 dition.

3 “(8) The assigned claims agent in processing claims under ORS 656.054
4 shall send notice of acceptance or denial to the noncomplying employer.

5 “(9) If an insurer or any other duly authorized agent of the employer for
6 such purpose, on record with the Director of the Department of Consumer
7 and Business Services denies a claim for compensation, written notice of
8 such denial, stating the reason for the denial, and informing the worker of
9 the Expedited Claim Service and of hearing rights under ORS 656.283, shall
10 be given to the claimant. The insurer shall issue a copy of the notice of de-
11 nial to the employer. The insurer shall notify the director of the denial in
12 the manner the director prescribes by rule. The worker may request a hear-
13 ing pursuant to ORS 656.319.

14 “(10) Merely paying or providing compensation shall not be considered
15 acceptance of a claim or an admission of liability, nor shall mere acceptance
16 of such compensation be considered a waiver of the right to question the
17 amount thereof. Payment of permanent disability benefits pursuant to a no-
18 tice of closure, reconsideration order or litigation order, or the failure to
19 appeal or seek review of such an order or notice of closure, shall not pre-
20 clude an insurer or self-insured employer from subsequently contesting the
21 compensability of the condition rated therein, unless the condition has been
22 formally accepted.

23 “(11)(a) If the insurer or self-insured employer unreasonably delays or
24 unreasonably refuses to pay compensation, attorney fees or costs, or unrea-
25 sonably delays acceptance or denial of a claim, the insurer or self-insured
26 employer shall be liable for an additional amount up to 25 percent of the
27 amounts then due plus any attorney fees assessed under this section. The fees
28 assessed by the director, an Administrative Law Judge, the board or the
29 court under this section shall be reasonable attorney fees. In assessing fees,
30 the director, an Administrative Law Judge, the board or the court shall

1 consider the proportionate benefit to the injured worker. The board shall
2 adopt rules for establishing the amount of the attorney fee, giving primary
3 consideration to the results achieved and to the time devoted to the case.
4 An attorney fee awarded pursuant to this subsection may not exceed \$4,000
5 absent a showing of extraordinary circumstances. The maximum attorney fee
6 awarded under this paragraph shall be adjusted annually on July 1 by the
7 same percentage increase as made to the average weekly wage defined in
8 ORS 656.211, if any. Notwithstanding any other provision of this chapter,
9 the director shall have exclusive jurisdiction over proceedings regarding
10 solely the assessment and payment of the additional amount and attorney
11 fees described in this subsection. The action of the director and the review
12 of the action taken by the director shall be subject to review under ORS
13 656.704.

14 “(b) When the director does not have exclusive jurisdiction over pro-
15 ceedings regarding the assessment and payment of the additional amount and
16 attorney fees described in this subsection, the provisions of this subsection
17 shall apply in the other proceeding.

18 “(12)(a) If payment is due on a disputed claim settlement authorized by
19 ORS 656.289 and the insurer or self-insured employer has failed to make the
20 payment in accordance with the requirements specified in the disputed claim
21 settlement, the claimant or the claimant’s attorney shall clearly notify the
22 insurer or self-insured employer in writing that the payment is past due. If
23 the required payment is not made within five business days after receipt of
24 the notice by the insurer or self-insured employer, the director may assess
25 a penalty and attorney fee in accordance with a matrix adopted by the di-
26 rector by rule.

27 “(b) The director shall adopt by rule a matrix for the assessment of the
28 penalties and attorney fees authorized under this subsection. The matrix
29 shall provide for penalties based on a percentage of the settlement proceeds
30 allocated to the claimant and for attorney fees based on a percentage of the

1 settlement proceeds allocated to the claimant's attorney as an attorney fee.

2 “(13) The insurer may authorize an employer to pay compensation to in-
3 jured workers and shall reimburse employers for compensation so paid.

4 “(14)(a) Injured workers have the duty to cooperate and assist the insurer
5 or self-insured employer in the investigation of claims for compensation. In-
6 jured workers shall submit to and shall fully cooperate with personal and
7 telephonic interviews and other formal or informal information gathering
8 techniques. Injured workers who are represented by an attorney shall have
9 the right to have the attorney present during any personal or telephonic
10 interview or deposition. If the injured worker is represented by an attorney,
11 the insurer or self-insured employer shall pay the attorney a reasonable at-
12 torney fee based upon an hourly rate for actual time spent during the per-
13 sonal or telephonic interview or deposition. After consultation with the
14 Board of Governors of the Oregon State Bar, the Workers' Compensation
15 Board shall adopt rules for the establishment, assessment and enforcement
16 of an hourly attorney fee rate specified in this subsection.

17 “(b) If the attorney is not willing or available to participate in an inter-
18 view at a time reasonably chosen by the insurer or self-insured employer
19 within 14 days of the request for interview and the insurer or self-insured
20 employer has cause to believe that the attorney's unwillingness or unavail-
21 ability is unreasonable and is preventing the worker from complying within
22 14 days of the request for interview, the insurer or self-insured employer
23 shall notify the director. If the director determines that the attorney's un-
24 willingness or unavailability is unreasonable, the director shall assess a civil
25 penalty against the attorney of not more than \$1,000.

26 “(15) If the director finds that a worker fails to reasonably cooperate with
27 an investigation involving an initial claim to establish a compensable injury
28 or an aggravation claim to reopen the claim for a worsened condition, the
29 director shall suspend all or part of the payment of compensation after notice
30 to the worker. If the worker does not cooperate for an additional 30 days

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

18 "(16) In accordance with ORS 656.283 (3), the Administrative Law Judge
19 assigned a request for hearing for a claim for compensation involving more
20 than one potentially responsible employer or insurer may specify what is
21 required of an injured worker to reasonably cooperate with the investigation
22 of the claim as required by subsection (14) of this section.

23 "**SECTION 50.** ORS 656.268 is amended to read:

24 "656.268. (1) One purpose of this chapter is to restore the injured worker
25 as soon as possible and as near as possible to a condition of self support and
26 maintenance as an able-bodied worker. The insurer or self-insured employer
27 shall close the worker's claim, as prescribed by the Director of the Depart-
28 ment of Consumer and Business Services, and determine the extent of the
29 worker's permanent disability, provided the worker is not enrolled and ac-
30 tively engaged in training according to rules adopted by the director pursu-

1 ant to ORS 656.340 and 656.726, when one of the following conditions is met:

2 “(a) The worker has become medically stationary and there is sufficient
3 information to determine permanent disability. Notwithstanding any other
4 provision of this chapter, a physician [*or nurse practitioner*] may not
5 retroactively determine a worker to be medically stationary more than 60
6 days prior to the date of the determination except in the case of claims that
7 are subject to subsection (13) of this section. An insurer or self-insured em-
8 ployer must mail or deliver written notice to a worker and to the worker’s
9 attorney, if the worker is represented, within seven days following receipt
10 of information that the worker is medically stationary.

11 “(b) The accepted injury is no longer the major contributing cause of the
12 worker’s combined or consequential condition or conditions pursuant to ORS
13 656.005 (7). When the claim is closed because the accepted injury is no longer
14 the major contributing cause of the worker’s combined or consequential
15 condition or conditions, and there is sufficient information to determine
16 permanent disability, the likely permanent disability that would have been
17 due to the current accepted condition shall be estimated.

18 “(c) Without the approval of the attending physician [*or nurse practitioner*
19 *authorized to provide compensable medical services under ORS 656.245*], the
20 worker fails to seek medical treatment for a period of 30 days or the worker
21 fails to attend a closing examination, unless the worker affirmatively estab-
22 lishes that such failure is attributable to reasons beyond the worker’s con-
23 trol.

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

27 “(2) If the worker is enrolled and actively engaged in training according
28 to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disa-
29 bility compensation shall be proportionately reduced by any sums earned
30 during the training.

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

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

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

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

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

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

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

26 “(C) Is not with the employer at injury;

27 “(D) Is not at a work site of the employer at injury;

28 “(E) Is not consistent with the existing written shift change policy or is
29 not consistent with common practice of the employer at injury or aggra-
30 vation; or

1 “(F) Is not consistent with an existing shift change provision of an ap-
2 plicable collective bargaining agreement;

3 “(d) Any other event that causes temporary disability benefits to be law-
4 fully suspended, withheld or terminated under ORS 656.262 (4) or other pro-
5 visions of this chapter; or

6 “(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection,
7 the attending physician [*or nurse practitioner who has authorized temporary*
8 *disability benefits under ORS 656.245*] for a home care worker or a personal
9 support worker who has been made a subject worker pursuant to ORS 656.039
10 advises the home care worker or personal support worker and documents in
11 writing that the home care worker or personal support worker is released
12 to return to modified employment, appropriate modified employment is of-
13 fered in writing by the Home Care Commission or a designee of the com-
14 mission to the home care worker or personal support worker for any client
15 of the Department of Human Services who employs a home care worker or
16 personal support worker and the worker fails to begin the employment.

17 “(5)(a) Findings by the insurer or self-insured employer regarding the ex-
18 tent of the worker’s disability in closure of the claim shall be pursuant to
19 the standards prescribed by the director.

20 “(b) The insurer or self-insured employer shall issue a notice of closure
21 of the claim to the worker and to the worker’s attorney if the worker is re-
22 presented. The insurer or self-insured employer shall notify the director of
23 the closure in the manner the director prescribes by rule. If the worker is
24 deceased at the time the notice of closure is issued, the insurer or self-
25 insured employer shall mail the worker’s copy of the notice of closure, ad-
26 dressed to the estate of the worker, to the worker’s last known address and
27 may mail copies of the notice of closure to any known or potential benefi-
28 ciaries to the estate of the deceased worker.

29 “(c) The notice of closure must inform:

30 “(A) The parties, in boldfaced type, of the proper manner in which to

1 proceed if they are dissatisfied with the terms of the notice of closure;

2 “(B) The worker of:

3 “(i) The amount of any further compensation, including permanent disa-
4 bility compensation to be awarded;

5 “(ii) The duration of temporary total or temporary partial disability
6 compensation;

7 “(iii) The right of the worker or beneficiaries of the worker who were
8 mailed a copy of the notice of closure under paragraph (b) of this subsection
9 to request reconsideration by the director under this section within 60 days
10 of the date of the notice of closure;

11 “(iv) The right of beneficiaries who were not mailed a copy of the notice
12 of closure under paragraph (b) of this subsection to request reconsideration
13 by the director under this section within one year of the date the notice of
14 closure was mailed to the estate of the worker under paragraph (b) of this
15 subsection;

16 “(v) The right of the insurer or self-insured employer to request recon-
17 sideration by the director under this section within seven days of the date
18 of the notice of closure;

19 “(vi) The aggravation rights; and

20 “(vii) Any other information as the director may require; and

21 “(C) Any beneficiaries of death benefits to which they may be entitled
22 pursuant to ORS 656.204 and 656.208.

23 “(d) If the insurer or self-insured employer has not issued a notice of
24 closure, the worker may request closure. Within 10 days of receipt of a
25 written request from the worker, the insurer or self-insured employer shall
26 issue a notice of closure if the requirements of this section have been met
27 or a notice of refusal to close if the requirements of this section have not
28 been met. A notice of refusal to close shall advise the worker of:

29 “(A) The decision not to close;

30 “(B) The right of the worker to request a hearing pursuant to ORS 656.283

1 within 60 days of the date of the notice of refusal to close;

2 “(C) The right to be represented by an attorney; and

3 “(D) Any other information as the director may require.

4 “(e) If a worker, a worker’s beneficiary, an insurer or a self-insured em-
5 ployer objects to the notice of closure, the objecting party first must request
6 reconsideration by the director under this section. A worker’s request for
7 reconsideration must be made within 60 days of the date of the notice of
8 closure. If the worker is deceased at the time the notice of closure is issued,
9 a request for reconsideration by a beneficiary of the worker who was mailed
10 a copy of the notice of closure under paragraph (b) of this subsection must
11 be made within 60 days of the date of the notice of closure. A request for
12 reconsideration by a beneficiary to the estate of a deceased worker who was
13 not mailed a copy of the notice of closure under paragraph (b) of this sub-
14 section must be made within one year of the date the notice of closure was
15 mailed to the estate of the worker under paragraph (b) of this subsection.
16 A request for reconsideration by an insurer or self-insured employer may be
17 based only on disagreement with the findings used to rate impairment and
18 must be made within seven days of the date of the notice of closure.

19 “(f) If an insurer or self-insured employer has closed a claim or refused
20 to close a claim pursuant to this section, if the correctness of that notice
21 of closure or refusal to close is at issue in a hearing on the claim and if a
22 finding is made at the hearing that the notice of closure or refusal to close
23 was not reasonable, a penalty shall be assessed against the insurer or self-
24 insured employer and paid to the worker in an amount equal to 25 percent
25 of all compensation determined to be then due the claimant.

26 “(g) If, upon reconsideration of a claim closed by an insurer or self-
27 insured employer, the director orders an increase by 25 percent or more of
28 the amount of compensation to be paid to the worker for permanent disabil-
29 ity and the worker is found upon reconsideration to be at least 20 percent
30 permanently disabled, a penalty shall be assessed against the insurer or

1 self-insured employer and paid to the worker in an amount equal to 25 per-
2 cent of all compensation determined to be then due the claimant. If the in-
3 crease in compensation results from information that the insurer or
4 self-insured employer demonstrates the insurer or self-insured employer could
5 not reasonably have known at the time of claim closure, from new informa-
6 tion obtained through a medical arbiter examination or from a determination
7 order issued by the director that addresses the extent of the worker's per-
8 manent disability that is not based on the standards adopted pursuant to
9 ORS 656.726 (4)(f), the penalty shall not be assessed.

10 “(6)(a) Notwithstanding any other provision of law, only one reconsider-
11 ation proceeding may be held on each notice of closure. At the reconsider-
12 ation proceeding:

13 “(A) A deposition arranged by the worker, limited to the testimony and
14 cross-examination of the worker about the worker's condition at the time of
15 claim closure, shall become part of the reconsideration record. The deposi-
16 tion must be conducted subject to the opportunity for cross-examination by
17 the insurer or self-insured employer and in accordance with rules adopted
18 by the director. The cost of the court reporter, interpreter services, if nec-
19 essary, and one original of the transcript of the deposition for the Depart-
20 ment of Consumer and Business Services and one copy of the transcript of
21 the deposition for each party shall be paid by the insurer or self-insured
22 employer. The reconsideration proceeding may not be postponed to receive
23 a deposition taken under this subparagraph. A deposition taken in accord-
24 ance with this subparagraph may be received as evidence at a hearing even
25 if the deposition is not prepared in time for use in the reconsideration pro-
26 ceeding.

27 “(B) Pursuant to rules adopted by the director, the worker or the insurer
28 or self-insured employer may correct information in the record that is erro-
29 neous and may submit any medical evidence that should have been but was
30 not submitted by the attending physician [*or nurse practitioner authorized to*

1 *provide compensable medical services under ORS 656.245]* at the time of claim
2 closure.

3 “(C) If the director determines that a claim was not closed in accordance
4 with subsection (1) of this section, the director may rescind the closure.

5 “(b) If necessary, the director may require additional medical or other
6 information with respect to the claims and may postpone the reconsideration
7 for not more than 60 additional calendar days.

8 “(c) In any reconsideration proceeding under this section in which the
9 worker was represented by an attorney, the director shall order the insurer
10 or self-insured employer to pay to the attorney, out of the additional com-
11 pensation awarded, an amount equal to 10 percent of any additional com-
12 pensation awarded to the worker.

13 “(d) Except as provided in subsection (7) of this section, the reconsider-
14 ation proceeding shall be completed within 18 working days from the date
15 the reconsideration proceeding begins, and shall be performed by a special
16 evaluation appellate unit within the department. The deadline of 18 working
17 days may be postponed by an additional 60 calendar days if within the 18
18 working days the department mails notice of review by a medical arbiter. If
19 an order on reconsideration has not been mailed on or before 18 working
20 days from the date the reconsideration proceeding begins, or within 18
21 working days plus the additional 60 calendar days where a notice for medical
22 arbiter review was timely mailed or the director postponed the reconsider-
23 ation pursuant to paragraph (b) of this subsection, or within such additional
24 time as provided in subsection (8) of this section when reconsideration is
25 postponed further because the worker has failed to cooperate in the medical
26 arbiter examination, reconsideration shall be deemed denied and any further
27 proceedings shall occur as though an order on reconsideration affirming the
28 notice of closure was mailed on the date the order was due to issue.

29 “(e) The period for completing the reconsideration proceeding described
30 in paragraph (d) of this subsection begins upon receipt by the director of a

1 worker's or a beneficiary's request for reconsideration pursuant to subsection
2 (5)(e) of this section. If the insurer or self-insured employer requests recon-
3 sideration, the period for reconsideration begins upon the earlier of the date
4 of the request for reconsideration by the worker or beneficiary, the date of
5 receipt of a waiver from the worker or beneficiary of the right to request
6 reconsideration or the date of expiration of the right of the worker or ben-
7 eficiary to request reconsideration. If a party elects not to file a separate
8 request for reconsideration, the party does not waive the right to fully par-
9 ticipate in the reconsideration proceeding, including the right to proceed
10 with the reconsideration if the initiating party withdraws the request for
11 reconsideration.

12 “(f) Any medical arbiter report may be received as evidence at a hearing
13 even if the report is not prepared in time for use in the reconsideration
14 proceeding.

15 “(g) If any party objects to the reconsideration order, the party may re-
16 quest a hearing under ORS 656.283 within 30 days from the date of the re-
17 consideration order.

18 “(7)(a) The director may delay the reconsideration proceeding and toll the
19 reconsideration timeline established under subsection (6) of this section for
20 up to 45 calendar days if:

21 “(A) A request for reconsideration of a notice of closure has been made
22 to the director within 60 days of the date of the notice of closure;

23 “(B) The parties are actively engaged in settlement negotiations that in-
24 clude issues in dispute at reconsideration;

25 “(C) The parties agree to the delay; and

26 “(D) Both parties notify the director before the 18th working day after the
27 reconsideration proceeding has begun that they request a delay under this
28 subsection.

29 “(b) A delay of the reconsideration proceeding granted by the director
30 under this subsection expires:

1 “(A) If a party requests the director to resume the reconsideration pro-
2 ceeding before the expiration of the delay period;

3 “(B) If the parties reach a settlement and the director receives a copy of
4 the approved settlement documents before the expiration of the delay period;

5 or

6 “(C) On the next calendar day following the expiration of the delay period
7 authorized by the director.

8 “(c) Upon expiration of a delay granted under this subsection, the
9 timeline for the completion of the reconsideration proceeding shall resume
10 as if the delay had never been granted.

11 “(d) Compensation due the worker shall continue to be paid during the
12 period of delay authorized under this subsection.

13 “(e) The director may authorize only one delay period for each reconsid-
14 eration proceeding.

15 “(8)(a) If the basis for objection to a notice of closure issued under this
16 section is disagreement with the impairment used in rating of the worker’s
17 disability, the director shall refer the claim to a medical arbiter appointed
18 by the director.

19 “(b) If the director determines that insufficient medical information is
20 available to determine disability, the director may appoint, and refer the
21 claim to, a medical arbiter.

22 “(c) At the request of either of the parties, the director shall appoint a
23 panel of as many as three medical arbiters in accordance with criteria that
24 the director sets by rule.

25 “(d) The arbiter, or panel of medical arbiters, must be chosen from among
26 a list of physicians qualified to be attending physicians referred to in ORS
27 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon
28 Medical Board, **the Oregon State Board of Nursing** and the committee
29 referred to in ORS 656.790.

30 “(e)(A) The medical arbiter or panel of medical arbiters may examine the

1 worker and perform such tests as may be reasonable and necessary to es-
2 tablish the worker's impairment.

3 “(B) If the director determines that the worker failed to attend the ex-
4 amination without good cause or failed to cooperate with the medical arbi-
5 ter, or panel of medical arbiters, the director shall postpone the
6 reconsideration proceedings for up to 60 days from the date of the determi-
7 nation that the worker failed to attend or cooperate, and shall suspend all
8 disability benefits resulting from this or any prior opening of the claim until
9 such time as the worker attends and cooperates with the examination or the
10 request for reconsideration is withdrawn. Any additional evidence regarding
11 good cause must be submitted prior to the conclusion of the 60-day
12 postponement period.

13 “(C) At the conclusion of the 60-day postponement period, if the worker
14 has not attended and cooperated with a medical arbiter examination or es-
15 tablished good cause, the worker may not attend a medical arbiter examina-
16 tion for this claim closure. The reconsideration record must be closed, and
17 the director shall issue an order on reconsideration based upon the existing
18 record.

19 “(D) All disability benefits suspended under this subsection, including all
20 disability benefits awarded in the order on reconsideration, or by an Ad-
21 ministrative Law Judge, the Workers' Compensation Board or upon court
22 review, are not due and payable to the worker.

23 “(f) The insurer or self-insured employer shall pay the costs of examina-
24 tion and review by the medical arbiter or panel of medical arbiters.

25 “(g) The findings of the medical arbiter or panel of medical arbiters must
26 be submitted to the director for reconsideration of the notice of closure.

27 “(h) After reconsideration, no subsequent medical evidence of the
28 worker's impairment is admissible before the director, the Workers' Com-
29 pensation Board or the courts for purposes of making findings of impairment
30 on the claim closure.

1 “(i)(A) If the basis for objection to a notice of closure issued under this
2 section is a disagreement with the impairment used in rating the worker’s
3 disability, and the director determines that the worker is not medically sta-
4 tionary at the time of the reconsideration or that the closure was not made
5 pursuant to this section, the director is not required to appoint a medical
6 arbiter before completing the reconsideration proceeding.

7 “(B) If the worker’s condition has substantially changed since the notice
8 of closure, upon the consent of all the parties to the claim, the director shall
9 postpone the proceeding until the worker’s condition is appropriate for claim
10 closure under subsection (1) of this section.

11 “(9) No hearing shall be held on any issue that was not raised and pre-
12 served before the director at reconsideration. However, issues arising out
13 of the reconsideration order may be addressed and resolved at hearing.

14 “(10) If, after the notice of closure issued pursuant to this section, the
15 worker becomes enrolled and actively engaged in training according to rules
16 adopted pursuant to ORS 656.340 and 656.726, any permanent disability pay-
17 ments due for work disability under the closure shall be suspended, and the
18 worker shall receive temporary disability compensation and any permanent
19 disability payments due for impairment while the worker is enrolled and
20 actively engaged in the training. When the worker ceases to be enrolled and
21 actively engaged in the training, the insurer or self-insured employer shall
22 again close the claim pursuant to this section if the worker is medically
23 stationary or if the worker’s accepted injury is no longer the major contrib-
24 uting cause of the worker’s combined or consequential condition or condi-
25 tions pursuant to ORS 656.005 (7). The closure shall include the duration of
26 temporary total or temporary partial disability compensation. Permanent
27 disability compensation shall be redetermined for work disability only. If the
28 worker has returned to work or the worker’s attending physician has re-
29 leased the worker to return to regular or modified employment, the insurer
30 or self-insured employer shall again close the claim. This notice of closure

1 may be appealed only in the same manner as are other notices of closure
2 under this section.

3 “(11) If the attending physician [*or nurse practitioner authorized to provide*
4 *compensable medical services under ORS 656.245*] has approved the worker’s
5 return to work and there is a labor dispute in progress at the place of em-
6 ployment, the worker may refuse to return to that employment without loss
7 of reemployment rights or any vocational assistance provided by this chap-
8 ter.

9 “(12) Any notice of closure made under this section may include necessary
10 adjustments in compensation paid or payable prior to the notice of closure,
11 including disallowance of permanent disability payments prematurely made,
12 crediting temporary disability payments against current or future permanent
13 or temporary disability awards or payments and requiring the payment of
14 temporary disability payments which were payable but not paid.

15 “(13) An insurer or self-insured employer may take a credit or offset of
16 previously paid workers’ compensation benefits or payments against any
17 further workers’ compensation benefits or payments due a worker from that
18 insurer or self-insured employer when the worker admits to having obtained
19 the previously paid benefits or payments through fraud, or a civil judgment
20 or criminal conviction is entered against the worker for having obtained the
21 previously paid benefits through fraud. Benefits or payments obtained
22 through fraud by a worker may not be included in any data used for
23 ratemaking or individual employer rating or dividend calculations by an
24 insurer, a rating organization licensed pursuant to ORS chapter 737, the
25 State Accident Insurance Fund Corporation or the director.

26 “(14)(a) An insurer or self-insured employer may offset any compensation
27 payable to the worker to recover an overpayment from a claim with the same
28 insurer or self-insured employer. When overpayments are recovered from
29 temporary disability or permanent total disability benefits, the amount re-
30 covered from each payment shall not exceed 25 percent of the payment,

1 without prior authorization from the worker.

2 “(b) An insurer or self-insured employer may suspend and offset any
3 compensation payable to the beneficiary of the worker, and recover an
4 overpayment of permanent total disability benefits caused by the failure of
5 the worker’s beneficiaries to notify the insurer or self-insured employer
6 about the death of the worker.

7 “(15) Conditions that are direct medical sequelae to the original accepted
8 condition shall be included in rating permanent disability of the claim unless
9 they have been specifically denied.

10 “(16)(a) Except as provided under subsection (13) of this section, an
11 insurer or self-insured employer may not recover an overpayment from a
12 worker’s permanent partial disability compensation for overpayments, offsets
13 or credits of wage loss in an amount that exceeds 50 percent of the total
14 compensation awarded to the worker.

15 “(b) An insurer or self-insured employer may not declare an overpayment
16 of any compensation that was paid more than two years prior to the date
17 of the declaration.

18 **“SECTION 51.** ORS 656.325 is amended to read:

19 “656.325. (1)(a) Any worker entitled to receive compensation under this
20 chapter is required, if requested by the Director of the Department of Con-
21 sumer and Business Services, the insurer or self-insured employer, to submit
22 to a medical examination at a time reasonably convenient for the worker as
23 may be provided by the rules of the director. No more than three independent
24 medical examinations may be requested except after notification to and au-
25 thorization by the director. If the worker refuses to submit to any such ex-
26 amination, or obstructs the same, the rights of the worker to compensation
27 shall be suspended with the consent of the director until the examination
28 has taken place, and no compensation shall be payable during or for account
29 of such period. The provisions of this paragraph are subject to the limita-
30 tions on medical examinations provided in ORS 656.268.

1 “(b) When a worker is requested by the director, the insurer or self-
2 insured employer to attend an independent medical examination, the exam-
3 ination must be conducted by a physician selected from a list of qualified
4 physicians established by the director under ORS 656.328.

5 “(c) The director shall adopt rules applicable to independent medical ex-
6 aminations conducted pursuant to paragraph (a) of this subsection that:

7 “(A) Provide a worker the opportunity to request review by the director
8 of the reasonableness of the location selected for an independent medical
9 examination. Upon receipt of the request for review, the director shall con-
10 duct an expedited review of the location selected for the independent medical
11 examination and issue an order on the reasonableness of the location of the
12 examination. The director shall determine if there is substantial evidence for
13 the objection to the location for the independent medical examination based
14 on a conclusion that the required travel is medically contraindicated or
15 other good cause establishing that the required travel is unreasonable. The
16 determinations of the director about the location of independent medical
17 examinations are not subject to review.

18 “(B) Impose a monetary penalty against a worker who fails to attend an
19 independent medical examination without prior notification or without jus-
20 tification for not attending the examination. A penalty imposed under this
21 subparagraph may be imposed only on a worker who is not receiving tem-
22 porary disability benefits under ORS 656.210 or 656.212. An insurer or self-
23 insured employer may offset any future compensation payable to the worker
24 to recover any penalty imposed under this subparagraph from a claim with
25 the same insurer or self-insured employer. When a penalty is recovered from
26 temporary disability or permanent total disability benefits, the amount re-
27 covered from each payment may not exceed 25 percent of the benefit payment
28 without prior authorization from the worker.

29 “(C) Impose a sanction against a medical service provider that unreason-
30 ably fails to provide in a timely manner diagnostic records required for an

1 independent medical examination.

2 “(d) Notwithstanding ORS 656.262 (6), if the director determines that the
3 location selected for an independent medical examination is unreasonable,
4 the insurer or self-insured employer shall accept or deny the claim within
5 90 days after the employer has notice or knowledge of the claim.

6 “(e) If the worker has made a timely request for a hearing on a denial
7 of compensability as required by ORS 656.319 (1)(a) that is based on one or
8 more reports of examinations conducted pursuant to paragraph (a) of this
9 subsection and the worker’s attending physician [*or nurse practitioner au-*
10 *thorized to provide compensable medical services under ORS 656.245*] does not
11 concur with the report or reports, the worker may request an examination
12 to be conducted by a physician selected by the director from the list de-
13 scribed in ORS 656.328. The cost of the examination and the examination
14 report shall be paid by the insurer or self-insured employer.

15 “(f) The insurer or self-insured employer shall pay the costs of the medical
16 examination and related services which are reasonably necessary to allow
17 the worker to submit to any examination requested under this section. As
18 used in this paragraph, ‘related services’ includes, but is not limited to, child
19 care, travel, meals, lodging and an amount equivalent to the worker’s net
20 lost wages for the period during which the worker is absent if the worker
21 does not receive benefits pursuant to ORS 656.210 (4) during the period of
22 absence. A claim for ‘related services’ described in this paragraph shall be
23 made in the manner prescribed by the director.

24 “(g) A worker who objects to the location of an independent medical ex-
25 amination must request review by the director under paragraph (c)(A) of this
26 subsection within six business days of the date the notice of the independent
27 medical examination was mailed.

28 “(2) For any period of time during which any worker commits insanitary
29 or injurious practices which tend to either imperil or retard recovery of the
30 worker, or refuses to submit to such medical or surgical treatment as is

1 reasonably essential to promote recovery, or fails to participate in a program
2 of physical rehabilitation, the right of the worker to compensation shall be
3 suspended with the consent of the director and no payment shall be made for
4 such period. The period during which such worker would otherwise be enti-
5 tled to compensation may be reduced with the consent of the director to such
6 an extent as the disability has been increased by such refusal.

7 “(3) A worker who has received an award for permanent total or perma-
8 nent partial disability should be encouraged to make a reasonable effort to
9 reduce the disability; and the award shall be subject to periodic examination
10 and adjustment in conformity with ORS 656.268.

11 “(4) When the employer of an injured worker, or the employer’s insurer
12 determines that the injured worker has failed to follow medical advice from
13 the attending physician [*or nurse practitioner authorized to provide*
14 *compensable medical services under ORS 656.245*] or has failed to participate
15 in or complete physical restoration or vocational rehabilitation programs
16 prescribed for the worker pursuant to this chapter, the employer or insurer
17 may petition the director for reduction of any benefits awarded the worker.
18 Notwithstanding any other provision of this chapter, if the director finds
19 that the worker has failed to accept treatment as provided in this subsection,
20 the director may reduce any benefits awarded the worker by such amount
21 as the director considers appropriate.

22 “(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or
23 self-insured employer shall cease making payments pursuant to ORS 656.210
24 and shall commence making payment of such amounts as are due pursuant
25 to ORS 656.212 when an injured worker refuses wage earning employment
26 prior to claim determination and the worker’s attending physician [*or nurse*
27 *practitioner authorized to provide compensable medical services under ORS*
28 *656.245*], after being notified by the employer of the specific duties to be
29 performed by the injured worker, agrees that the injured worker is capable
30 of performing the employment offered.

1 “(b) If the worker has been terminated for violation of work rules or other
2 disciplinary reasons, the insurer or self-insured employer shall cease pay-
3 ments pursuant to ORS 656.210 and commence payments pursuant to ORS
4 656.212 when the attending physician [*or nurse practitioner authorized to*
5 *provide compensable medical services under ORS 656.245*] approves employ-
6 ment in a modified job that would have been offered to the worker if the
7 worker had remained employed, provided that the employer has a written
8 policy of offering modified work to injured workers.

9 “(c) If the worker is a person present in the United States in violation
10 of federal immigration laws, the insurer or self-insured employer shall cease
11 payments pursuant to ORS 656.210 and commence payments pursuant to ORS
12 656.212 when the attending physician [*or nurse practitioner authorized to*
13 *provide compensable medical services under ORS 656.245*] approves employ-
14 ment in a modified job whether or not such a job is available.

15 “(6) Any party may request a hearing on any dispute under this section
16 pursuant to ORS 656.283.

17 **“SECTION 52.** ORS 656.340 is amended to read:

18 “656.340. (1)(a) The insurer or self-insured employer shall cause vocational
19 assistance to be provided to an injured worker who is eligible for assistance
20 in returning to work.

21 “(b) For this purpose the insurer or self-insured employer shall contact a
22 worker with a claim for a disabling compensable injury or claim for aggra-
23 vation for evaluation of the worker’s eligibility for vocational assistance
24 within five days of:

25 “(A) Having knowledge of the worker’s likely eligibility for vocational
26 assistance, from a medical or investigation report, notification from the
27 worker, or otherwise; or

28 “(B) The time the worker is medically stationary, if the worker has not
29 returned to or been released for the worker’s regular employment or has not
30 returned to other suitable employment with the employer at the time of in-

1 jury or aggravation and the worker is not receiving vocational assistance.

2 “(c) Eligibility may be redetermined by the insurer or self-insured em-
3 ployer upon receipt of new information that would change the eligibility
4 determination.

5 “(2) Contact under subsection (1) of this section shall include informing
6 the worker about reemployment rights, the responsibility of the worker to
7 request reemployment, and wage subsidy and job site modification assistance
8 and the provisions of the preferred worker program pursuant to rules adopted
9 by the Director of the Department of Consumer and Business Services.

10 “(3) Within five days after notification that the attending physician [*or*
11 *nurse practitioner authorized to provide compensable medical services under*
12 *ORS 656.245*] has released a worker to return to work, the insurer or self-
13 insured employer shall inform the worker about the opportunity to seek re-
14 employment or reinstatement under ORS 659A.043 and 659A.046. The insurer
15 shall inform the employer of the worker’s reemployment rights, wage subsidy
16 and the job site modification assistance and the provisions of the preferred
17 worker program.

18 “(4) As soon as possible, and not more than 30 days after the contact re-
19 quired by subsection (1) of this section, the insurer or self-insured employer
20 shall cause an individual certified by the director to provide vocational as-
21 sistance to determine whether the worker is eligible for vocational assist-
22 ance. The insurer or self-insured employer shall notify the worker of the
23 decision regarding the worker’s eligibility for vocational assistance. If the
24 insurer or self-insured employer decides that the worker is not eligible, the
25 worker may apply to the director for review of the decision as provided in
26 subsection (16) of this section. A worker determined ineligible upon evalu-
27 ation under subsection (1)(b)(B) of this section, or because the worker’s el-
28 igibility has fully and finally expired under standards prescribed by the
29 director, may not be found eligible thereafter unless that eligibility deter-
30 mination is rejected by the director under subsection (16) of this section or

1 the worker's condition worsens so as to constitute an aggravation claim un-
2 der ORS 656.273. A worker is not entitled to vocational assistance benefits
3 when possible eligibility for such benefits arises from a worsening of the
4 worker's condition that occurs after the expiration of the worker's aggra-
5 vation rights under ORS 656.273.

6 “(5) The objectives of vocational assistance are to return the worker to
7 employment which is as close as possible to the worker's regular employment
8 at a wage as close as possible to the weekly wage currently being paid for
9 employment which was the worker's regular employment even though the
10 wage available following employment may be less than the wage prescribed
11 by subsection (6) of this section. As used in this subsection and subsection
12 (6) of this section, ‘regular employment’ means the employment the worker
13 held at the time of the injury or the claim for aggravation under ORS
14 656.273, whichever gave rise to the potential eligibility for vocational as-
15 sistance; or, for a worker not employed at the time of the aggravation, the
16 employment the worker held on the last day of work prior to the aggra-
17 vation.

18 “(6)(a) A worker is eligible for vocational assistance if the worker will
19 not be able to return to the previous employment or to any other available
20 and suitable employment with the employer at the time of injury or aggra-
21 vation, and the worker has a substantial handicap to employment.

22 “(b) As used in this subsection:

23 “(A) A ‘substantial handicap to employment’ exists when the worker, be-
24 cause of the injury or aggravation, lacks the necessary physical capacities,
25 knowledge, skills and abilities to be employed in suitable employment.

26 “(B) ‘Suitable employment’ means:

27 “(i) Employment of the kind for which the worker has the necessary
28 physical capacity, knowledge, skills and abilities;

29 “(ii) Employment that is located where the worker customarily worked
30 or is within reasonable commuting distance of the worker's residence; and

1 “(iii) Employment that produces a weekly wage within 20 percent of that
2 currently being paid for employment that was the worker’s regular employ-
3 ment as defined in subsection (5) of this section. The director shall adopt
4 rules providing methods of calculating the weekly wage currently being paid
5 for the worker’s regular employment for use in determining eligibility and
6 for providing assistance to eligible workers. If the worker’s regular employ-
7 ment was seasonal or temporary, the worker’s wage shall be averaged based
8 on a combination of the worker’s earned income and any unemployment in-
9 surance payments. Only earned income evidenced by verifiable documenta-
10 tion such as federal or state tax returns shall be used in the calculation.
11 Earned income does not include fringe benefits or reimbursement of the
12 worker’s employment expenses.

13 “(7) Vocational evaluation, help in directly obtaining employment and
14 training shall be available under conditions prescribed by the director. The
15 director may establish other conditions for providing vocational assistance,
16 including those relating to the worker’s availability for assistance, partic-
17 ipation in previous assistance programs connected with the same claim and
18 the nature and extent of assistance that may be provided. Such conditions
19 shall give preference to direct employment assistance over training.

20 “(8) An insurer or self-insured employer may utilize its own staff or may
21 engage any other individual certified by the director to perform the voca-
22 tional evaluation required by subsection (4) of this section.

23 “(9) The director shall adopt rules providing:

24 “(a) Standards for and methods of certifying individuals qualified by ed-
25 ucation, training and experience to provide vocational assistance to injured
26 workers;

27 “(b) Standards for registration of vocational assistance providers;

28 “(c) Conditions and procedures under which the certification of an indi-
29 vidual to provide vocational assistance services or the registration of a vo-
30 cational assistance provider may be suspended or revoked for failure to

1 maintain compliance with the certification or registration standards;

2 “(d) Standards for the nature and extent of services a worker may receive,
3 for plans for return to work and for determining when the worker has re-
4 turned to work; and

5 “(e) Procedures, schedules and conditions relating to the payment for
6 services performed by a vocational assistance provider, that are based on
7 payment for specific services performed and not fees for services performed
8 on an hourly basis. Fee schedules shall reflect a reasonable rate for direct
9 worker purchases and for all vocational assistance providers and shall be the
10 same within suitable geographic areas.

11 “(10) Insurers and self-insured employers shall maintain records and make
12 reports to the director of vocational assistance actions at times and in the
13 manner as the director may prescribe. The requirements prescribed shall be
14 for the purpose of assisting the Department of Consumer and Business Ser-
15 vices in monitoring compliance with this section to insure that workers re-
16 ceive timely and appropriate vocational assistance. The director shall
17 minimize to the greatest extent possible the number, extent and kinds of re-
18 ports required. The director shall compile a list of organizations or agencies
19 registered to provide vocational assistance. A current list shall be distributed
20 by the director to all insurers and self-insured employers. The insurer shall
21 send the list to each worker with the notice of eligibility.

22 “(11) When a worker is eligible to receive vocational assistance, the
23 worker and the insurer or self-insured employer shall attempt to agree on the
24 choice of a vocational assistance provider. If the worker agrees, the insurer
25 or self-insured employer may utilize its own staff to provide vocational as-
26 sistance. If they are unable to agree on a vocational assistance provider, the
27 insurer or self-insured employer shall notify the director and the director
28 shall select a provider. Any change in the choice of vocational assistance
29 provider is subject to the approval of the director.

30 “(12) Notwithstanding ORS 656.268, a worker actively engaged in training

1 may receive temporary disability compensation for a maximum of 16 months.
2 The insurer or self-insured employer may voluntarily extend the payment of
3 temporary disability compensation to a maximum of 21 months. The director
4 may order the payment of temporary disability compensation for up to 21
5 months upon good cause shown by the injured worker. The costs related to
6 vocational assistance training programs may be paid for periods longer than
7 21 months, but in no event may temporary disability benefits be paid for a
8 period longer than 21 months.

9 “(13) As used in this section, ‘vocational assistance provider’ means a
10 public or private organization or agency that provides vocational assistance
11 to injured workers.

12 “(14)(a) Determination of eligibility for vocational assistance does not
13 entitle all workers to the same type or extent of assistance.

14 “(b) Training shall not be provided to an eligible worker solely because
15 the worker cannot obtain employment, otherwise suitable, that will produce
16 the wage prescribed in subsection (6) of this section unless such training will
17 enable the worker to find employment which will produce a wage signif-
18 icantly closer to that prescribed in subsection (6) of this section.

19 “(c) Nothing in this section shall be interpreted to expand the availability
20 of training under this section.

21 “(15) A physical capacities evaluation shall be performed in conjunction
22 with vocational assistance or determination of eligibility for such assistance
23 at the request of the insurer or self-insured employer or worker. The request
24 shall be made to the attending physician [*or nurse practitioner authorized to*
25 *provide compensable medical services under ORS 656.245*]. [*The attending*
26 *physician or nurse practitioner,*] Within 20 days of the request, **the attending**
27 **physician** shall perform a physical capacities evaluation or refer the worker
28 for such evaluation or advise the insurer or self-insured employer and the
29 worker in writing that the injured worker is incapable of participating in a
30 physical capacities evaluation.

1 “(16)(a) The Legislative Assembly finds that vocational rehabilitation of
2 injured workers requires a high degree of cooperation between all of the
3 participants in the vocational assistance process. Based on this finding, the
4 Legislative Assembly concludes that disputes regarding eligibility for and
5 extent of vocational assistance services should be resolved through nonad-
6 versarial procedures to the greatest extent possible consistent with consti-
7 tutional principles. The director shall adopt by rule a procedure for resolving
8 vocational assistance disputes in the manner provided in this subsection.

9 “(b) If a worker is dissatisfied with an action of the insurer or self-insured
10 employer regarding vocational assistance, the worker must apply to the di-
11 rector for administrative review of the matter. Application for review must
12 be made not later than the 60th day after the date the worker was notified
13 of the action. The director shall complete the review within a reasonable
14 time.

15 “(c) If the worker’s dissatisfaction is resolved by agreement of the parties,
16 the agreement shall be reduced to writing, and the director and the parties
17 shall review the agreement and either approve or disapprove it. The agree-
18 ment is subject to reconsideration by the director under limitations pre-
19 scribed by the director, but is not subject to review by any other forum.

20 “(d) If the worker’s dissatisfaction is not resolved by agreement of the
21 parties, the director shall resolve the matter in a written order based on a
22 record sufficient to permit review. The order is subject to review under ORS
23 656.704. The request for a hearing must be filed within 60 days of the date
24 the order was issued. At the hearing, the order of the director shall be
25 modified only if it:

26 “(A) Violates a statute or rule;

27 “(B) Exceeds the statutory authority of the agency;

28 “(C) Was made upon unlawful procedure; or

29 “(D) Was characterized by abuse of discretion or clearly unwarranted
30 exercise of discretion.

1 “(e) For purposes of this subsection, the term ‘parties’ does not include
2 a noncomplying employer.

3 “**SECTION 53.** ORS 656.726 is amended to read:

4 “656.726. (1) The Workers’ Compensation Board in its name and the Di-
5 rector of the Department of Consumer and Business Services in the director’s
6 name as director may sue and be sued, and each shall have a seal.

7 “(2) The board hereby is charged with reviewing appealed orders of Ad-
8 ministrative Law Judges in controversies concerning a claim arising under
9 this chapter, exercising own motion jurisdiction under this chapter and pro-
10 viding such policy advice as the director may request, and providing such
11 other review functions as may be prescribed by law. To that end any of its
12 members or assistants authorized thereto by the members shall have power
13 to:

14 “(a) Hold sessions at any place within the state.

15 “(b) Administer oaths.

16 “(c) Issue and serve by the board’s representatives, or by any sheriff,
17 subpoenas for the attendance of witnesses and the production of papers,
18 contracts, books, accounts, documents and testimony before any hearing un-
19 der ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this
20 chapter.

21 “(d) Generally provide for the taking of testimony and for the recording
22 of proceedings.

23 “(3) The board chairperson is hereby charged with the administration of
24 and responsibility for the Hearings Division.

25 “(4) The director hereby is charged with duties of administration, regu-
26 lation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750
27 to 654.780 and this chapter. To that end the director may:

28 “(a) Make and declare all rules and issue orders which are reasonably
29 required in the performance of the director’s duties. Unless otherwise spec-
30 ified by law, all reports, claims or other documents shall be deemed timely

1 provided to the director or board if mailed by regular mail or delivered
2 within the time required by law. Notwithstanding any other provision of this
3 chapter, the director may adopt rules to allow for the electronic transmission
4 and filing of reports, claims or other documents required to be filed under
5 this chapter and to require the electronic transmission and filing of proof
6 of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding
7 ORS 183.310 to 183.410, if a matter comes before the director that is not ad-
8 dressed by rule and the director finds that adoption of a rule to accommodate
9 the matter would be inefficient, unreasonable or unnecessarily burdensome
10 to the public, the director may resolve the matter by issuing an order, sub-
11 ject to review under ORS 656.704. Such order shall not have precedential
12 effect as to any other situation.

13 “(b) Hold sessions at any place within the state.

14 “(c) Administer oaths.

15 “(d) Issue and serve by representatives of the director, or by any sheriff,
16 subpoenas for the attendance of witnesses and the production of papers,
17 contracts, books, accounts, documents and testimony in any inquiry, inves-
18 tigation, proceeding or rulemaking hearing conducted by the director or the
19 director’s representatives. The director may require the attendance and tes-
20 timony of employers, their officers and representatives in any inquiry under
21 this chapter, and the production by employers of books, records, papers and
22 documents without the payment or tender of witness fees on account of such
23 attendance.

24 “(e) Generally provide for the taking of testimony and for the recording
25 of such proceedings.

26 “(f) Provide standards for the evaluation of disabilities. The following
27 provisions apply to the standards:

28 “(A) The criterion for evaluation of permanent impairment under ORS
29 656.214 is the loss of use or function of a body part or system due to the
30 compensable industrial injury or occupational disease. Permanent impair-

1 ment is expressed as a percentage of the whole person. The impairment value
2 may not exceed 100 percent of the whole person.

3 “(B) Impairment is established by a preponderance of medical evidence
4 based upon objective findings.

5 “(C) The criterion for evaluation of work disability under ORS 656.214 is
6 permanent impairment as modified by the factors of age, education and
7 adaptability to perform a given job.

8 “(D) When, upon reconsideration of a notice of closure pursuant to ORS
9 656.268, it is found that the worker’s disability is not addressed by the stan-
10 dards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the
11 director shall, in the order on reconsideration, determine the extent of per-
12 manent disability that addresses the worker’s impairment.

13 “(E) Notwithstanding any other provision of this section, only impairment
14 benefits shall be awarded under ORS 656.214 if the worker has been released
15 to regular work by the attending physician [*or nurse practitioner authorized*
16 *to provide compensable medical services under ORS 656.245*] or has returned
17 to regular work at the job held at the time of injury.

18 “(g) Prescribe procedural rules for and conduct hearings, investigations
19 and other proceedings pursuant to ORS 654.001 to 654.295, 654.412 to 654.423,
20 654.750 to 654.780 and this chapter regarding all matters other than those
21 specifically allocated to the board or the Hearings Division.

22 “(h) Participate fully in any proceeding before the Hearings Division,
23 board or Court of Appeals in which the director determines that the pro-
24 ceeding involves a matter that affects or could affect the discharge of the
25 director’s duties of administration, regulation and enforcement of ORS
26 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

27 “(5)(a) The board may make and declare all rules which are reasonably
28 required in the performance of its duties, including but not limited to rules
29 of practice and procedure in connection with hearing and review proceedings
30 and exercising its authority under ORS 656.278. The board shall adopt stan-

1 dards governing the format and timing of the evidence. The standards shall
2 be uniformly followed by all Administrative Law Judges and practitioners.
3 The rules may provide for informal prehearing conferences in order to expedite
4 claim adjudication, amicably dispose of controversies, if possible, narrow
5 issues and simplify the method of proof at hearings. The rules shall specify
6 who may appear with parties at prehearing conferences and hearings.

7 “(b) Notwithstanding any other provision of this chapter, the board may
8 adopt rules to allow for the electronic transmission of filings, reports, notices
9 and other documents required to be filed under the board’s authority.

10 “(6) The director and the board chairperson may incur such expenses as
11 they respectively determine are reasonably necessary to perform their authorized
12 functions.

13 “(7) The director, the board chairperson and the State Accident Insurance
14 Fund Corporation shall have the right, not subject to review, to contract for
15 the exchange of, or payment for, such services between them as will reduce
16 the overall cost of administering this chapter.

17 “(8) The director shall have lien and enforcement powers regarding assessments
18 to be paid by subject employers in the same manner and to the same extent as
19 is provided for lien and enforcement of collection of premiums and assessments
20 by the corporation under ORS 656.552 to 656.566.

21 “(9) The director shall have the same powers regarding inspection of
22 books, records and payrolls of employers as are granted the corporation under
23 ORS 656.758. The director may disclose information obtained from such inspections
24 to the Director of the Department of Revenue to the extent the Director of the
25 Department of Revenue requires such information to determine that a person
26 complies with the revenue and tax laws of this state and to the Director of the
27 Employment Department to the extent the Director of the Employment Department
28 requires such information to determine that a person complies with ORS chapter
29 657.

30 “(10) The director shall collect hours-worked data information in addition

1 to total payroll for workers engaged in various jobs in the construction in-
2 dustry classifications described in the job classification portion of the
3 Workers' Compensation and Employers Liability Manual and the Oregon
4 Special Rules Section published by the National Council on Compensation
5 Insurance. The information shall be collected in the form and format neces-
6 sary for the National Council on Compensation Insurance to analyze pre-
7 mium equity.

8 **“SECTION 54.** ORS 656.797 is amended to read:

9 “656.797. On or after October 1, 2004, **prior to providing compensable**
10 **medical services or authorizing temporary disability benefits,** a nurse
11 practitioner licensed under ORS 678.375 to 678.390[*prior to providing*
12 *compensable medical services or authorizing temporary disability benefits un-*
13 *der ORS 656.245,*] **or a similarly licensed nurse practitioner in any**
14 **country or in any state, territory or possession of the United States**
15 must certify in a form acceptable to the Director of the Department of Con-
16 sumer and Business Services that the nurse practitioner has reviewed the
17 materials developed under ORS 656.795.

18 **“SECTION 55.** ORS 659A.043 is amended to read:

19 “659A.043. (1) A worker who has sustained a compensable injury shall be
20 reinstated by the worker's employer to the worker's former position of em-
21 ployment upon demand for such reinstatement, if the position exists and is
22 available and the worker is not disabled from performing the duties of such
23 position. A worker's former position is available even if that position has
24 been filled by a replacement while the injured worker was absent. If the
25 former position is not available, the worker shall be reinstated in any other
26 existing position that is vacant and suitable. A certificate by the attending
27 physician, **as defined in ORS 656.005 (12),** [*or a nurse practitioner author-*
28 *ized to provide compensable medical services under ORS 656.245*] that the
29 **attending** physician [*or nurse practitioner*] approves the worker's return to
30 the worker's regular employment or other suitable employment shall be

1 prima facie evidence that the worker is able to perform such duties.

2 “(2) Such right of reemployment shall be subject to the provisions for
3 seniority rights and other employment restrictions contained in a valid col-
4 lective bargaining agreement between the employer and a representative of
5 the employer’s employees.

6 “(3) Notwithstanding subsection (1) of this section:

7 “(a) The right to reinstatement to the worker’s former position under this
8 section terminates when whichever of the following events first occurs:

9 “[*(A) A medical determination by the attending physician or, after an ap-
10 peal of such determination to a medical arbiter or panel of medical arbiters
11 pursuant to ORS chapter 656, has been made that the worker cannot return to
12 the former position of employment.*]

13 “**(A) The worker cannot return to the former position of employ-
14 ment according to:**

15 “**(i) The medical determination of the attending physician; or**

16 “**(ii) Upon appeal of the attending physician’s determination, the
17 determination of a medical arbiter or panel of medical arbiters pur-
18 suant to ORS chapter 656.**

19 “(B) The worker is eligible and participates in vocational assistance un-
20 der ORS 656.340.

21 “(C) The worker accepts suitable employment with another employer after
22 becoming medically stationary.

23 “(D) The worker refuses a bona fide offer from the employer of light duty
24 or modified employment that is suitable prior to becoming medically sta-
25 tionary.

26 “(E) Seven days elapse from the date that the worker is notified by the
27 insurer or self-insured employer by certified mail that the worker’s attending
28 physician [*or a nurse practitioner authorized to provide compensable medical
29 services under ORS 656.245*] has released the worker for employment unless
30 the worker requests reinstatement within that time period.

1 “(F) Three years elapse from the date of injury.

2 “(b) The right to reinstatement under this section does not apply to:

3 “(A) A worker hired on a temporary basis as a replacement for an injured
4 worker.

5 “(B) A seasonal worker employed to perform less than six months’ work
6 in a calendar year.

7 “(C) A worker whose employment at the time of injury resulted from re-
8 ferral from a hiring hall operating pursuant to a collective bargaining
9 agreement.

10 “(D) A worker whose employer employs 20 or fewer workers at the time
11 of the worker’s injury and at the time of the worker’s demand for rein-
12 statement.

13 “(4) Notwithstanding ORS 659A.165, a worker who refuses an offer of
14 employment under subsection (3)(a)(D) of this section and who otherwise is
15 entitled to family leave under ORS 659A.150 to 659A.186:

16 “(a) Automatically commences a period of family leave under ORS
17 659A.150 to 659A.186 upon refusing the offer of employment; and

18 “(b) Need not give additional written or oral notice to the employer that
19 the employee is commencing a period of family leave.

20 “(5) Any violation of this section is an unlawful employment practice.

21 **“SECTION 56.** ORS 659A.046 is amended to read:

22 “659A.046. (1) A worker who has sustained a compensable injury and is
23 disabled from performing the duties of the worker’s former regular employ-
24 ment shall, upon demand, be reemployed by the worker’s employer at em-
25 ployment which is available and suitable.

26 “(2) A certificate of the worker’s attending physician, **as defined in ORS**
27 **656.005 (12)**, [*or a nurse practitioner authorized to provide compensable med-*
28 *ical services under ORS 656.245*] that the worker is able to perform described
29 types of work shall be prima facie evidence of such ability.

30 “(3) Notwithstanding subsection (1) of this section, the right to reem-

1 ployment under this section terminates when whichever of the following
2 events first occurs:

3 “[*a*) *The worker cannot return to reemployment at any position with the*
4 *employer either by determination of the attending physician or a nurse practi-*
5 *tioner authorized to provide compensable medical services under ORS 656.245*
6 *or upon appeal of that determination, by determination of a medical arbiter*
7 *or panel of medical arbiters pursuant to ORS chapter 656.*]

8 **“(a) The worker cannot return to reemployment at any position**
9 **with the employer according to:**

10 **“(A) The determination of the attending physician; or**

11 **“(B) Upon appeal of the attending physician’s determination, the**
12 **determination of a medical arbiter or panel of medical arbiters pur-**
13 **suant to ORS chapter 656.**

14 **“(b) The worker is eligible and participates in vocational assistance under**
15 **ORS 656.340.**

16 **“(c) The worker accepts suitable employment with another employer after**
17 **becoming medically stationary.**

18 **“(d) The worker refuses a bona fide offer from the employer of light duty**
19 **or modified employment that is suitable prior to becoming medically sta-**
20 **tionary.**

21 **“(e) Seven days elapse from the date that the worker is notified by the**
22 **insurer or self-insured employer by certified mail that the worker’s attending**
23 **physician [*or a nurse practitioner authorized to provide compensable medical***
24 ***services under ORS 656.245*] has released the worker for reemployment unless**
25 **the worker requests reemployment within that time period.**

26 **“(f) Three years elapse from the date of injury.**

27 **“(4) Such right of reemployment shall be subject to the provisions for**
28 **seniority rights and other employment restrictions contained in a valid col-**
29 **lective bargaining agreement between the employer and a representative of**
30 **the employer’s employees.**

1 “(5) Notwithstanding ORS 659A.165, a worker who refuses an offer of
2 employment under subsection (3)(d) of this section and who otherwise is en-
3 titled to family leave under ORS 659A.150 to 659A.186:

4 “(a) Automatically commences a period of family leave under ORS
5 659A.150 to 659A.186 upon refusing the offer of employment; and

6 “(b) Need not give additional written or oral notice to the employer that
7 the employee is commencing a period of family leave.

8 “(6) Any violation of this section is an unlawful employment practice.

9 “(7) This section applies only to employers who employ six or more per-
10 sons.

11 **“SECTION 57.** ORS 659A.049 is amended to read:

12 “659A.049. The rights of reinstatement **and reemployment** afforded by
13 ORS 659A.043 and 659A.046 shall not be forfeited if the worker refuses to
14 return to the worker’s regular or other offered employment without release
15 to such employment by the worker’s attending physician **as defined in ORS**
16 **656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical*
17 *services under ORS 656.245*].

18 **“SECTION 58.** ORS 659A.063 is amended to read:

19 “659A.063. (1) The State of Oregon shall cause group health benefits to
20 continue in effect with respect to that worker and any covered dependents
21 or family members by timely payment of the premium that includes the con-
22 tribution due from the state under the applicable benefit plan, subject to any
23 premium contribution due from the worker that the worker paid before the
24 occurrence of the injury or illness. If the premium increases or decreases, the
25 State of Oregon and worker contributions shall be adjusted to remain con-
26 sistent with similarly situated active employees. The State of Oregon shall
27 continue the worker’s health benefits in effect until whichever of the fol-
28 lowing events occurs first:

29 “(a) The worker’s attending physician **as defined in ORS 656.005 (12)**
30 [*or a nurse practitioner authorized to provide compensable medical services*

1 *under ORS 656.245*] has determined the worker to be medically stationary
2 and a notice of closure has been entered;

3 “(b) The worker returns to work for the State of Oregon, after a period
4 of continued coverage under this section, and satisfies any probationary or
5 minimum work requirement to be eligible for group health benefits;

6 “(c) The worker takes full- or part-time employment with another em-
7 ployer that is comparable in terms of the number of hours per week the
8 worker was employed with the State of Oregon or the worker retires;

9 “(d) Twelve months have elapsed since the date the State of Oregon re-
10 ceived notice that the worker filed a workers’ compensation claim pursuant
11 to ORS chapter 656;

12 “(e) The claim is denied and the claimant fails to appeal within the time
13 provided by ORS 656.319 or the Workers’ Compensation Board or a workers’
14 compensation hearings referee or a court issues an order finding the claim
15 is not compensable;

16 “(f) The worker does not pay the required premium or portion thereof in
17 a timely manner in accordance with the terms and conditions under this
18 section;

19 “(g) The worker elects to discontinue coverage under this section and
20 notifies the State of Oregon in writing of this election;

21 “(h) The worker’s attending physician [*or a nurse practitioner authorized*
22 *to provide compensable medical services under ORS 656.245*] has released the
23 worker to modified or regular work, the work has been offered to the worker
24 and the worker refuses to return to work; or

25 “(i) The worker has been terminated from employment for reasons unre-
26 lated to the workers’ compensation claim.

27 “(2) If the workers’ compensation claim of a worker for whom health
28 benefits are provided pursuant to subsection (1) of this section is denied and
29 the worker does not appeal or the worker appeals and does not prevail, the
30 State of Oregon may recover from the worker the amount of the premiums

1 plus interest at the rate authorized by ORS 82.010. The State of Oregon may
2 recover the payments through a payroll deduction not to exceed 10 percent
3 of gross pay for each pay period.

4 “(3) The State of Oregon shall notify the worker of the provisions of ORS
5 659A.060 to 659A.069, and of the remedies available for breaches of ORS
6 659A.060 to 659A.069, within a reasonable time after the State of Oregon re-
7 ceives notice that the worker will be absent from work as a result of an in-
8 jury or illness for which a workers’ compensation claim has been filed
9 pursuant to ORS chapter 656. The notice from the State of Oregon shall in-
10 clude the terms and conditions of the continuation of health benefits and
11 what events will terminate the coverage.

12 “(4) If the worker fails to make timely payment of any premium contri-
13 bution owing, the State of Oregon shall notify the worker of impending
14 cancellation of the health benefits and provide the worker with 30 days to
15 pay the required premium prior to canceling the policy.

16 “(5) It is an unlawful employment practice for the State of Oregon to
17 discriminate against a worker, as defined in ORS 659A.060, by terminating
18 the worker’s group health benefits while that worker is absent from the place
19 of employment as a result of an injury or illness for which a workers’ com-
20 pensation claim has been filed pursuant to ORS chapter 656, except as pro-
21 vided for in this section.

22 **“SECTION 59.** ORS 657.170 is amended to read:

23 “657.170. (1) If the Director of the Employment Department finds that
24 during the base year of the individual any individual has been incapable of
25 work during the greater part of any calendar quarter, such base year shall
26 be extended a calendar quarter. Except as provided in subsection (2) of this
27 section, no such extension of an individual’s base year shall exceed four
28 calendar quarters.

29 “(2) If the director finds that during and prior to the individual’s base
30 year the individual has had a period of temporary total disability caused by

1 illness or injury and has received compensation under ORS chapter 656 for
2 a period of temporary total disability during the greater part of any calendar
3 quarter, the individual's base year shall be extended as many calendar
4 quarters as necessary to establish a valid claim, up to a maximum of four
5 calendar quarters prior to the quarter in which the illness or injury oc-
6 curred, if the individual:

7 “(a) Files a claim for benefits not later than the fourth calendar week of
8 unemployment following whichever is the latest of the following dates:

9 “(A) The date the individual is released to return to work by the attend-
10 ing physician[, *as defined in ORS chapter 656, or a nurse practitioner au-*
11 *thorized to provide compensable medical services under ORS 656.245*] **as**
12 **defined in ORS 656.005 (12);** or

13 “(B) The date of mailing of a notice of claim closure pursuant to ORS
14 chapter 656; and

15 “(b) Files such a claim within the three-year period immediately following
16 the commencement of such period of illness or injury.

17 “(3) Notwithstanding the provisions of this section, benefits payable as a
18 result of the use of wages paid in a calendar quarter prior to the individual's
19 current base year shall not exceed one-third of such wages less benefits paid
20 previously as a result of the use of such wages in computing a previous
21 benefit determination.

22

23

“CAPTIONS

24

25 **“SECTION 60. The unit captions used in this 2026 Act are provided**
26 **only for the convenience of the reader and do not become part of the**
27 **statutory law of this state or express any legislative intent in the**
28 **enactment of this 2026 Act.**

29

30

“EFFECTIVE DATE

