Enrolled
Senate Bill 559

Sponsored by COMMITTEE ON COMMERCE

CHAPTER .....

AN ACT

Relating to workers' compensation guaranty contracts; creating new provisions; and amending ORS 654.097, 656.005, 656.039, 656.128, 656.210, 656.268, 656.407, 656.419, 656.423, 656.427, 656.440, 656.443, 656.447, 656.622, 656.628, 656.726, 656.730, 656.740, 656.850, 731.158, 731.475, 731.480, 731.590, 731.608, 731.628, 737.602 and 746.145.

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

SECTION 1. ORS 656.419 is amended to read:

656.419. (1) A [*guaranty contract*] **workers' compensation insurance policy** issued by an insurer **under this section** shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer, arising during the period the [*guaranty contract*] **policy** is in effect, for prompt payment of all compensation for compensable injuries that may become due under this chapter to subject workers and their beneficiaries.

(2)**(a)** [*A guaranty contract issued by a guaranty contract*] **The** insurer **issuing the workers' compensation insurance policy** shall [*be filed*] **file proof of coverage** with the Director of the Department of Consumer and Business Services [*by the insurer*] within 30 days after workers' compensation coverage of the employer is effective. The filing shall be in [*such*] **the** form and manner **and shall include any information that** [*as*] the director may prescribe **by rule**. [*A guaranty contract shall contain:*]

[*(a) The name and address of the employer;*]

[*(b) A description of the occupation in which the employer is engaged or proposes to engage;*]

[*(c) The effective date of the workers' compensation coverage;*]

[*(d) Notice that an employer has elected to provide coverage pursuant to ORS 656.039; and*]

[*(e) Such other information as the director may from time to time require.*]

(b) An insurer shall file the proof of coverage required under this section for each new or renewed policy issued by the insurer.

(3) Workers' compensation coverage is effective when the application of the subject employer for coverage together with any required fees or premium are received and accepted by an authorized representative of an insurer **or on the date specified in writing by the employer and the insurer**.

[*(4) If the name or address of an insured employer is changed, the insurer shall, within 30 days after the date the change is received by the insurer, file a change-of-name or change-of-address notice with the director setting forth the correct name and address of the employer.*]

[*(5)*] **(4)** Coverage of an employer under a [*guaranty contract*] **workers' compensation insurance policy** continues until [*canceled or terminated as provided by ORS 656.423 or 656.427.*]**:**

(a) The expiration of the term of the policy;

(b) The coverage is canceled prior to the expiration date of the policy as provided by ORS 656.423 or 656.427;

(c) Another insurer files proof of coverage on behalf of the employer; or

(d) The employer becomes self-insured under ORS 656.430.

SECTION 2. ORS 656.423 is amended to read:

656.423. (1) An insured employer may cancel coverage with the insurer by giving the insurer at least 30 days' written notice, unless a shorter period is permitted by subsection (3) of this section.

(2) Cancellation of coverage is effective at 12 midnight 30 days after the date the cancellation notice is received by an authorized representative of the insurer, unless a later date is specified.

(3) An employer may cancel coverage effective less than 30 days after written notice is received by an [*agent*] **authorized representative** of the insurer by providing other coverage**,** [*or*] by becoming a self-insured employer **or by agreement of the employer and the insurer**. A cancellation under this subsection is effective immediately upon the effective date of the other coverage**, on** [*or*] the effective date of certification as a self-insured employer **or on a date agreed upon in writing by the employer and insurer**.

(4) The insurer shall file a notice of cancellation with the Director of the Department of Consumer and Business Services within 10 calendar days after the effective date of the cancellation or the date on which the insurer receives the notice required under subsection (1) of this section, whichever is later. The notice required under this subsection shall be in the form and manner and shall contain any information that the director may prescribe by rule.

SECTION 3. ORS 656.427 is amended to read:

656.427. (1) An insurer that issues [*a guaranty contract or a surety bond*] **a workers' compensation insurance policy or surety bond** to an employer under this chapter may [*terminate liability on its contract or bond, as the case may be,*] **cancel the policy or surety bond prior to the expiration date of the policy or surety bond** by giving the employer and the Director of the Department of Consumer and Business Services notice of [*termination*] **cancellation** in accordance with rules adopted by the director. [*A notice of termination shall state the effective date of termination.*] **Notice required under this section must be provided to the director within 10 calendar days after the effective date of the cancellation provided in the notice given to the employer.**

(2) An insurer may [*terminate liability*] **cancel a workers' compensation insurance policy or surety bond** under this section as follows:

(a) If the [*termination of a guaranty contract*] **cancellation** is for reasons other than those set forth in paragraph (b) of this subsection, it is effective at 12 midnight not less than 30 days after the date the notice is mailed to the employer.

(b) If the [*termination of a guaranty contract*] **cancellation** is based on the insurer's decision not to offer insurance to employers within a specific premium category, it is effective not sooner than 90 days after the date the notice is mailed to the employer.

(c) The termination of a surety bond is effective at 12 midnight not less than 30 days after the date the notice is received by the director.

(3) An insurer may nonrenew a workers' compensation insurance policy by providing notice in the manner provided for in subsection (2) of this section.

[*(3)*] **(4)** Notice to the employer under this section shall be given by mail, addressed to the employer at the last-known address of the employer. If the employer is a partnership, notice may be given to any of the partners. If the employer is a limited liability company, notice may be given to any manager, or in a member managed limited liability company, to any of the members. If the employer is a corporation, notice may be given to any agent or officer of the corporation under whom legal process may be served.

[*(4)*] **(5)** [*Termination*] **Cancellation of a workers' compensation insurance policy or surety bond** shall in no way limit liability that was incurred under the [*guaranty contract or surety bond*] **policy or surety bond** prior to the effective date of the [*termination*] **cancellation**.

[*(5)*] **(6)** If, before the effective date of a [*termination*] **cancellation** under this section, the employer gives notice to the insurer that it has not obtained coverage from another insurer and intends

to become insured under the assigned risk plan established under ORS 656.730, the insurer shall [*insure*] **ensure** that continuing coverage is provided to the employer under the plan without further application by the employer, transferring the risk to the plan as of the effective date of [*termination*] **cancellation**. If the insurer is a servicing carrier under the plan, it shall continue to provide coverage for the employer as a servicing carrier, at least until another servicing carrier is provided for the employer in the normal course of administering the plan. If the insurer is not a servicing carrier, it shall apply to the plan for coverage on the employer's behalf. Nothing in this section is intended to limit the authority of administrators of the plan to require the employer to provide deposits or to make payments consistent with plan requirements. However, the rules of the plan shall allow any deposit requirements imposed by the plan to be deferred for as long as one year.

(7) The cancellation of a workers' compensation insurance policy under this section is effective on the earliest of:

(a) The expiration of the term of the policy;

(b) The effective date of a cancellation under subsection (2) of this section; or

(c) The effective date of a policy for which another insurer makes a proof of coverage filing on behalf of the employer.

SECTION 4. ORS 656.726 is amended to read:

656.726. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter **and to require the electronic transmission and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427**. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS 656.704. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-

timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. Permanent impairment is expressed as a percentage of the whole person. The impairment value may not exceed 100 percent of the whole person.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment as modified by the factors of age, education and adaptability to perform a given job.

(D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

(E) Notwithstanding any other provision of this section, only impairment benefits shall be awarded under ORS 656.214 if the worker has been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has returned to regular work at the job held at the time of injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295 and 654.750 to 654.780 and this chapter.

(5) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person

complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity.

SECTION 5. ORS 656.726, as amended by section 4, chapter 657, Oregon Laws 2003, section 18, chapter 811, Oregon Laws 2003, section 17, chapter 26, Oregon Laws 2005, and section 2a, chapter 653, Oregon Laws 2005, is amended to read:

656.726. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter **and to require the electronic transmission and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427**. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS 656.704. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criteria for evaluation of disabilities under ORS 656.214 (5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214 (5) if:

(i) The worker returns to regular work at the job held at the time of injury;

(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295 and 654.750 to 654.780 and this chapter.

(5) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon

Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity.

SECTION 6. ORS 656.005 is amended to read:

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

(2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

(a) A spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time received or attempted by process of law to collect funds for support or maintenance is considered living in a state of abandonment.

(b) A person who intentionally causes the compensable injury to or death of an injured worker.

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

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

(5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. An invalid dependent child is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, an invalid dependent child is considered to be a child under 18 years of age.

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

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

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

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

(b) "Compensable injury" does not include:

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

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

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

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

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

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

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

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

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

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

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

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

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

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

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

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

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

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

(16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

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

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

(19) "Objective findings" in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and

palpable muscle spasm. "Objective findings" does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable.

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

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

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

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

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

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

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

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

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

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

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

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

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

(27) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

(28) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

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

which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

(30) "Worker" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

(31) "Independent contractor" has the meaning for that term provided in ORS 670.600.

SECTION 7. ORS 656.005, as amended by section 2, chapter 811, Oregon Laws 2003, is amended to read:

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

(2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

(a) A spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time received or attempted by process of law to collect funds for support or maintenance is considered living in a state of abandonment.

(b) A person who intentionally causes the compensable injury to or death of an injured worker.

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

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

(5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. An invalid dependent child is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, an invalid dependent child is considered to be a child under 18 years of age.

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

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

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

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

(b) "Compensable injury" does not include:

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

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

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

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

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

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

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

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

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

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

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

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

(c) "Consulting physician" means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury.

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

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

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

(14) [*"Guaranty contract insurer" and*] "Insurer" [*mean*] **means** the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compen-

sation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

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

(16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(27) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

(28) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

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

(30) "Worker" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

(31) "Independent contractor" has the meaning for that term provided in ORS 670.600.

SECTION 8. ORS 656.039 is amended to read:

656.039. (1) An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a carrier-insured employer, the election shall be made by filing written notice thereof with the insurer with a copy to the Director of the Department of Consumer and Business Services. The effective date of coverage is governed by ORS 656.419 (3). If the employer is or becomes a self-insured employer, the election shall be made by filing written notice thereof with the director, the effective date of coverage to be the date specified in the notice.

(2) Any election under subsection (1) of this section may be canceled by written notice thereof to the insurer or, in the case of a self-insured employer, by notice thereof to the director. The cancellation is effective at 12 midnight ending the day the notice is received by the insurer or the director, unless a later date is specified in the notice. The insurer shall, within 10 days after receipt of a notice of cancellation under this section, send a copy of the notice to the director.

(3) When necessary the insurer or the director shall fix assumed minimum or maximum wages for persons made subject workers under this section.

(4) Notwithstanding any other provision of this section, a person or employer not subject to this chapter who elects to become covered may apply to [*a guaranty contract*] **an** insurer for coverage. An insurer other than the State Accident Insurance Fund Corporation may provide such coverage. However, the State Accident Insurance Fund Corporation shall accept any written notice filed and provide coverage as provided in this section if all subject workers of the employers will be insured with the State Accident Insurance Fund Corporation and the coverage of those subject workers is not considered by the State Accident Insurance Fund Corporation to be a risk properly assignable to the assigned risk pool.

SECTION 9. ORS 656.128 is amended to read:

656.128. (1) Any person who is a sole proprietor, or a member, including a member who is a manager, of a limited liability company, or a member of a partnership, or an independent contractor pursuant to ORS 670.600, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a

classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter.

(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. The person shall promptly notify the insurer whenever the status of the person as an employer of subject workers changes. Any subject worker employed by such a person after the effective date of the election of the person shall, upon being employed, be considered covered automatically by the same [*guaranty contract*] **workers' compensation insurance policy** that covers such person.

(3) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.

(4) Any person subject to this chapter as a worker as provided in this section may cancel such election by giving written notice to the insurer. The cancellation shall become effective at 12 midnight ending the day of filing the notice with the insurer.

SECTION 10. ORS 656.210 is amended to read:

656.210. (1) When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 133 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is less. Notwithstanding the limitation imposed by this subsection, an injured worker who is not otherwise eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have the benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year.

(2)(a) For the purpose of this section, the weekly wage of workers shall be ascertained:

(A) For workers employed in one job at the time of injury, by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed; or

(B) For workers employed in more than one job at the time of injury, by adding all earnings the worker was receiving from all subject employment.

(b) Notwithstanding paragraph (a)(B) of this subsection, the weekly wage calculated under paragraph (a)(A) of this subsection shall be used for workers employed in more than one job at the time of injury unless, within 30 days of receipt of the initial claim, the insurer, self-insured employer or assigned claims agent for a noncomplying employer receives notice that the worker was employed in more than one job with a subject employer at the time of injury and receives verifiable documentation of wages from such additional employment.

(c) Notwithstanding ORS 656.005 (7)(c), an injury to a worker employed in more than one job at the time of injury is not disabling if no temporary disability benefits are payable for time lost from the job at injury. Claim costs incurred as a result of supplemental temporary disability benefits paid as provided in subsection (5) of this section may not be included in any data used for ratemaking or individual employer rating or dividend calculations by [*a guaranty contract*] **an** insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services if the injured worker is not eligible for permanent disability benefits or temporary disability benefits for time lost from the job at injury.

(d) For the purpose of this section:

(A) The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.

(B) The benefits of a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits shall be based on the wage of the worker at the worker's last regular employment.

(e) As used in this subsection, "regularly employed" means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or

whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage.

(3) No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.

(4) When an injured worker with an accepted disabling compensable injury is required to leave work for a period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent, until such time as the worker is determined to be medically stationary. However, benefits under this subsection are not payable if wages are paid for the period of absence by the employer.

(5)(a) The insurer of the employer at injury or the self-insured employer at injury, may elect to be responsible for payment of supplemental temporary disability benefits to a worker employed in more than one job at the time of injury. In accordance with rules adopted by the director, if the worker's weekly wage is determined under subsection (2)(a)(B) of this section, the insurer or self-insured employer shall be reimbursed from the Workers' Benefit Fund for the amount of temporary disability benefits paid that exceeds the amount payable pursuant to subsection (2)(a)(A) of this section had the worker been employed in only one job at the time of injury. Such reimbursement shall include an administrative fee payable to the insurer or self-insured employer pursuant to rules adopted by the director.

(b) If the insurer or self-insured employer elects not to pay the supplemental temporary disability benefits for a worker employed in more than one job at the time of injury, the director shall either administer and pay the supplemental benefits directly or shall assign responsibility to administer and process the payment to a paying agent selected by the director.

SECTION 11. ORS 656.268 is amended to read:

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

(a) The worker has become medically stationary and there is sufficient information to determine permanent disability;

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent disability, the likely permanent disability that would have been due to the current accepted condition shall be estimated;

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

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

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

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

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

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

(b) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to regular employment;

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

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician or the nurse practitioner who may authorize temporary disability under ORS 656.245;

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

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement; or

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the worker's attorney if the worker is represented, and to the director. The notice must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice;

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within 60 days of the date of the notice of claim closure; of the right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(b) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of the decision not to close; of the right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to

close the claim; of the right to be represented by an attorney; and of such other information as the director may require.

(c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(d) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) The reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the

reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (7) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's request for reconsideration pursuant to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker, the date of receipt of a waiver from the worker of the right to request reconsideration or the date of expiration of the right of the worker to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If neither party requests a medical arbiter and the director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.

(c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

(d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the director in consultation with the Board of Medical Examiners for the State of Oregon and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, there shall be no further opportunity for the worker to attend a medical arbiter examination for this claim closure. The reconsideration record shall be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended pursuant to this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, shall not be due and payable to the worker.

(f) The costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid by the insurer or self-insured employer.

(g) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter prior to the completion of the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(8) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due for work disability under the closure shall be suspended, and the worker shall receive temporary disability compensation and any permanent disability payments due for impairment while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(10) If the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(11) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(12) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by [*a guaranty contract*] **an** insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(13)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(14) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

SECTION 12. ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12, chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461, Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

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

(a) The worker has become medically stationary and there is sufficient information to determine permanent impairment;

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent impairment, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated;

(c) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or

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

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

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

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

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

(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician;

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

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement; or

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the worker's attorney if the worker is represented, and to the director. The notice must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice;

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within 60 days of the date of the notice of claim closure; of the right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(b) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of the decision not to close; of the right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close the claim; of the right to be represented by an attorney; and of such other information as the director may require.

(c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(d) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) The reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (7) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's request for reconsideration pursuant to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker, the date of receipt of a waiver from the worker of the right to request reconsideration or the date of expiration of the right of the worker to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If neither party requests a medical arbiter and the director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.

(c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

(d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the director in consultation with the Board of Medical Examiners for the State of Oregon and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, there shall be no further opportunity for the worker to attend a medical arbiter examination for this claim closure. The reconsideration record shall be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended pursuant to this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, shall not be due and payable to the worker.

(f) The costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid by the insurer or self-insured employer.

(g) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter prior to the completion of the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(8) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Perma-

nent disability compensation shall be redetermined for unscheduled disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(10) If the attending physician has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(11) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(12) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by [*a guaranty contract*] **an** insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(13)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(14) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

SECTION 13. ORS 656.407 is amended to read:

656.407. (1) An employer shall establish proof with the Director of the Department of Consumer and Business Services that the employer is qualified either:

(a) As a carrier-insured employer by causing [*a guaranty contract issued by a guaranty contract*] **proof of coverage provided by an** insurer to be filed with the director; or

(b) As a self-insured employer by establishing proof that the employer has an adequate staff qualified to process claims promptly and has the financial ability to make certain the prompt payment of all compensation and other payments that may become due to the director under this chapter.

(2) Except as provided in subsection (3) of this section, a self-insured employer shall establish proof of financial ability by providing security that the director determines acceptable by rule. The security must be in an amount reasonably sufficient to insure payment of compensation and other payments that may become due to the director but not less than the employer's normal expected annual claim liabilities and in no event less than $100,000. In arriving at the amount of security required under this subsection, the director may take into consideration the financial ability of the employer to pay compensation and other payments and probable continuity of operation. The security shall be held by the director to secure the payment of compensation for injuries to subject workers of the employer and to secure other payments that may become due from the employer to the director under this chapter. Moneys received as security under this subsection shall be depos-

ited with the State Treasurer in an account separate and distinct from the General Fund. Interest earned by the account shall be credited to the account. The amount of security may be increased or decreased from time to time by the director.

(3)(a) A city or county that wishes to be exempt from subsection (2) of this section may make written application therefor to the director. The application shall include a copy of the city's or county's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740, information regarding the establishment of a loss reserve account for the payment of compensation to injured workers and such other information as the director may require. The director shall approve the application and the city or county shall be exempt from subsection (2) of this section if the director finds that:

(A) The city or county has been a self-insured employer in compliance with subsection (2) of this section for more than three consecutive years prior to making the application referred to in this subsection as an independently self-insured employer and not as part of a self-insured group.

(B) The city or county has in effect a loss reserve account:

(i) That is actuarially sound and that is adequately funded as determined by an annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director pursuant to this chapter. A copy of the annual audit shall be filed with the director. Upon a finding that there is probable cause to believe that the loss reserve account is not actuarially sound, the director may require a city or county to obtain an independent actuarial audit of the loss reserve account. The requirements of this subsection are in addition to and not in lieu of any other audit or reporting requirement otherwise prescribed by or pursuant to law.

(ii) That is dedicated to and may be expended only for the payment of compensation and amounts due the director by the city or county under this chapter.

(b) The director shall have the first lien and priority right to the full amount of the loss reserve account required to pay the present discounted value of all present and future claims under this chapter.

(c) The city or county shall notify the director no later than 60 days prior to any action to discontinue the loss reserve account. The city or county shall advise the director of the city's or county's plans to submit the security deposits required in subsection (2) of this section, or obtain coverage as a carrier-insured employer prior to the date the loss reserve account ceases to exist. If the city or county elects to discontinue self-insurance, it shall submit such security as the director may require to insure payment of all compensation and amounts due the director for the period the city or county was self-insured.

(d) In order to requalify as a self-insured employer, the city or county must deposit prior to discontinuance of the loss reserve account such security as is required by the director pursuant to subsection (2) of this section.

(e) Notwithstanding ORS 656.440, if prior to the date of discontinuance of the loss reserve account the director has not received the security deposits required in subsection (2) of this section, the city's or county's certificate of self-insurance is automatically revoked as of that date.

SECTION 14. ORS 656.443 is amended to read:

656.443. (1) If an employer defaults in payment of compensation or other payments due to the Director of the Department of Consumer and Business Services under this chapter, the director may, on notice to the employer and any insurer providing [*a guaranty contract or surety bond*] **workers' compensation insurance coverage or a surety bond** to such employer, use money or interest and dividends on securities, sell securities or institute legal proceedings on any surety bond or [*guaranty contract deposited or*] **insurance policy for which a notice of coverage has been** filed with the director to the extent necessary to make such payments.

(2) Prior to any default by the employer, the employer is entitled to all interest and dividends on securities on deposit and to exercise all voting rights, stock options and other similar incidents of ownership of the securities.

[*(3) If for any reason the certification of a self-insured employer is canceled or terminated, or the coverage of a carrier-insured employer is canceled or terminated, the security deposited or the guaranty*

contract filed with the director shall remain on deposit or in effect, as the case may be, for a period of at least 62 months after the employer ceases to be a self-insured or a carrier-insured employer. The security or contract shall be maintained in such amount as is necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by such security or contract, and to assure the payment of claims for aggravation and claims under ORS 656.278 based on such accidental injuries. At the expiration of the 62 months' period, or such other period as the director may consider proper, the director may accept in lieu of any such security or contract a policy of paid-up insurance in a form approved by the director.]

(3) If for any reason the certification of a self-insured employer is canceled or terminated, the security deposited with the director shall remain on deposit or in effect, as the case may be, for a period of at least 62 months after the employer ceases to be a self-insured employer. The security shall be maintained in an amount necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by the security, and to assure the payment of claims for aggravation and claims arising under ORS 656.278 based on those accidental injuries. At the expiration of the 62-month period, or of another period the director may consider proper, the director may accept in lieu of the security deposited with the director a policy of paid-up insurance in a form approved by the director.

SECTION 15. ORS 656.447 is amended to read:

656.447. (1) The Director of the Department of Consumer and Business Services may suspend or revoke the authorization of [*a guaranty contract*] **an** insurer to issue [*guaranty contracts*] **workers' compensation insurance policies** if the director, after notice to the company and giving the company an opportunity to be heard and present evidence, finds that:

(a) The company has failed to comply with its obligations under any such [*contract*] **policy**; or

(b) The company has failed to comply with the orders of the director or the provisions of this chapter or any rule promulgated pursuant thereto.

(2) A suspension or revocation shall not affect the liability of any such company on any [*guaranty contract*] **workers' compensation insurance policy** in force prior to the suspension or revocation.

SECTION 16. ORS 656.622 is amended to read:

656.622. (1) There is established a Reemployment Assistance Program for the benefit of employers and workers and for the purpose of:

(a) Giving employers and workers the benefits provided in this section.

(b) Providing reimbursement of reasonable program administration costs of self-insured employers and of insurers of employers who participate in any program funded through the Reemployment Assistance Program.

(2) In order to preclude or reduce nondisabling claims from becoming disabling claims, preclude on-the-job injuries from recurring, reduce disability by returning injured workers to work sooner and to help injured workers remain employed, the Director of the Department of Consumer and Business Services may provide assistance to employers from the Reemployment Assistance Program in such manner and amount as the director considers appropriate. Assistance may include, but need not be limited to, modification of work sites. For purposes of this subsection, work site modification may include engineering design work and occupational health consulting services. Factors to be considered by the director in determining the extent of assistance must include but need not be limited to the financial stability and solvency of employers, the employer's record of returning injured workers to the workplace and the cost-effectiveness of modifications. Assistance may be provided in the form of grants and matching contributions from employers for funds.

(3) In order to encourage the employment of individuals who have incurred compensable injuries that result in disability which may be a substantial obstacle to employment, the director may provide, to eligible injured workers and to employers who employ them, assistance from the Workers' Benefit Fund in such manner and amount as the director considers appropriate.

(4)(a) In addition to such assistance as the director may provide under this section, the director shall provide reimbursement to self-insured employers or to the insurers of employers who hire

preferred workers for the claim costs incurred for injuries to those workers during the first three years from the date of hire, as follows:

(A) The claim costs of injuries incurred by those workers.

(B) Reasonable claims administration costs.

(b) A worker may not waive eligibility for preferred worker status in the claim by agreement pursuant to ORS 656.236.

(5)(a) In addition to such assistance as the Director of the Department of Consumer and Business Services may provide under subsection (3) of this section, the director shall provide to participating self-insured employers and the insurers of participating employers reimbursement of reasonable program administration costs.

(b) As used in this subsection, "participating employer" or "participating self-insured employer" means an employer participating in any program funded through the Reemployment Assistance Program.

(6) Notwithstanding any other provision of law, determinations by the director regarding assistance pursuant to this section are not subject to review by any court or other administrative body.

(7) The Reemployment Assistance Program shall be funded with moneys collected as provided in ORS 656.506.

(8) Any assistance from the Reemployment Assistance Program shall be to the extent of the moneys available in the Workers' Benefit Fund, for the purpose of the program as determined by the director.

(9) The director may make such rules as may be required to establish, regulate, manage and disburse moneys in the Workers' Benefit Fund in accordance with the intent of this section. Such rules shall include, but are not limited to, the eligibility criteria to receive assistance under this section and the issuance of identity cards to preferred workers to assist employers in the administration of the program.

(10) Claims costs incurred as a result of an injury sustained by a preferred worker during the three years after that worker is hired shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by [*a guaranty contract*] **an** insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services. Neither insurance premiums nor premium assessments under this chapter are payable for preferred workers.

(11) Any moneys from the Workers' Benefit Fund reimbursed to an agency for costs incurred in reemploying injured state workers in the manner described in ORS 659A.052 or in providing wage subsidies for the reemployment of injured state workers shall be outside the biennial expenditure limitation imposed on the agency by the Legislative Assembly and shall be available for expenditure by the agency as a continuous appropriation.

(12) As used in this section, "preferred worker" means a worker who, because of a permanent disability resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment, whether or not an order has been issued awarding permanent disability.

SECTION 17. ORS 656.628 is amended to read:

656.628. (1) There is established a Handicapped Workers Program for the benefit of complying employers and their workers. The purpose of the program is to encourage the employment or reemployment of handicapped workers.

(2) As used in this section, "handicapped worker" means a worker who is afflicted with or subject to any permanent physical or mental impairment, whether congenital or due to an injury or disease, including periodic impairment of consciousness or muscular control of such character that the impairment would prevent the worker from obtaining or retaining employment.

(3) Any employer of a worker who claims or has received compensation under this chapter, or whose dependents have claimed or received such compensation, may file an application with the

Director of the Department of Consumer and Business Services requesting the director to make the determinations referred to in subsection (4) of this section.

(4) When the director receives a request referred to in subsection (3) of this section, the director shall determine:

(a) Whether the injured worker was a handicapped worker and whether the injury, disease or death sustained by the worker would not have been sustained except for the handicap; or

(b) Whether the injured worker was a handicapped worker and whether the injury, disease or death sustained by the worker would have been sustained without regard to the handicap but that:

(A) Any resulting disability was substantially greater by reason of the handicap; or

(B) The handicap contributed substantially to the worker's death; and

(C) Whether the injury, disease or death of the worker would not have occurred except for the act or omission of a handicapped worker employed by the same employer and that the act or omission of the handicapped worker would not have occurred except for the handicapped worker's impairment.

(5) If the director determines that any of the conditions described in subsection (4) of this section exist, the director may reimburse the paying agency for compensation amounts in excess of $1,000 per claimant for all subsequent injuries throughout the claimant's working career, paid as the result of the condition.

(6) The reimbursement paid from the Workers' Benefit Fund shall not be included in any data used for rate making or individual employer rating or dividend calculations by [*a guaranty contract*] **an** insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services.

(7) Notwithstanding any other provision of law:

(a) Any reimbursement to employers under the Handicapped Workers Program shall be in such amounts as the director prescribes and only to the extent of moneys available in the Workers' Benefit Fund as determined by the director.

(b) Determinations made by the director regarding reimbursement from the Workers' Benefit Fund for the purposes of this section are not subject to review by any court or administrative body.

(c) After a determination has been made by the director that an employer will receive reimbursement from the Workers' Benefit Fund, any settlement of the claim by the parties is void unless made with the written approval of the director.

(8) The director by rule shall prescribe the form and manner of requesting determinations under this section, the amount of reimbursement payable and such other matters as may be necessary for the administration of this section.

SECTION 18. ORS 656.730 is amended to read:

656.730. (1) The Director of the Department of Consumer and Business Services shall promulgate a plan for the equitable apportionment among the State Accident Insurance Fund Corporation and all members of workers' compensation rating organizations in the state coverage required by ORS 656.017 for subject employers whose coverage the fund, or any members of such rating organizations, object to providing. The plan shall include provisions authorized pursuant to ORS 737.265 (2), except that:

(a) Regardless of the rating plans adopted by any rating organization, the plan shall provide a rating structure with differing rate tiers for insureds too small to qualify for experience rating and for insureds large enough to be experience rated; and

(b) The plan shall seek and be entitled to receive approval for all classification exceptions approved by the director for any insurer.

(2) If any insurer issuing [*guaranty contracts*] **workers' compensation insurance policies** under this chapter refuses to accept its equitable apportionment under such plan, the director shall revoke the insurer's authority to issue [*guaranty contracts*] **workers' compensation insurance policies**.

SECTION 19. ORS 656.740 is amended to read:

656.740. (1) A person may contest a proposed order of the Director of the Department of Consumer and Business Services declaring that person to be a noncomplying employer, or a proposed

assessment of civil penalty, by filing with the Department of Consumer and Business Services, within 60 days after the mailing of the order, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment. An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect.

(2) A person may contest a nonsubjectivity determination of the director by filing a written request for hearing with the department within 60 days after the mailing of the determination.

(3) When any insurance carrier, including the State Accident Insurance Fund Corporation, is alleged by an employer to have contracted to provide the employer with workers' compensation coverage for the period in question, the Workers' Compensation Board shall join such insurance carrier as a necessary party to any hearing relating to such employer's alleged noncompliance or to any hearing relating to a nonsubjectivity determination and shall serve the carrier, at least 30 days prior to such hearing, with notice thereof.

(4) A hearing relating to a nonsubjectivity determination, to a proposed order declaring a person to be a noncomplying employer, or to a proposed assessment of civil penalty under ORS 656.735, shall be held by an Administrative Law Judge of the board's Hearings Division. However, a hearing shall not be granted unless a request for hearing is filed within the period specified in subsection (1) or (2) of this section, and if a request for hearing is not so filed, the nonsubjectivity determination, order or penalty, as proposed, shall be a final order of the department and shall not be subject to review by any agency or court.

(5) Notwithstanding ORS 183.315 (1), the issuance of nonsubjectivity determinations, orders declaring a person to be a noncomplying employer or the assessment of civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS chapter 183, except that:

(a) The order of an Administrative Law Judge in a contested case shall be deemed to be a final order of the director.

(b) The director shall have the same right to judicial review of the order of an Administrative Law Judge as any person who is adversely affected or aggrieved by such final order.

(c) When a nonsubjectivity determination or an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim.

(6)(a) If a person against whom an order is issued pursuant to this section prevails at hearing or on appeal, the person is entitled to reasonable attorney fees to be paid by the director from the Workers' Benefit Fund.

(b) If a person against whom an order is issued is found to be a noncomplying employer by the director, but the person proves coverage pursuant to subsection (3) of this section and the insurer failed to file timely [*a guaranty contract*] **proof of coverage** as required by ORS 656.419 or improperly canceled the person's coverage, the employer is entitled to reasonable attorney fees paid by the insurer.

(c) If a worker prevails at hearing or on appeal from a nonsubjectivity determination, the worker is entitled to reasonable attorney fees to be paid by the director from the Workers' Benefit Fund and reimbursed by the employer.

SECTION 20. ORS 656.850 is amended to read:

656.850. (1) As used in this section and ORS 656.018, 656.403, 656.855 and 737.270:

(a) "Worker leasing company" means a person who provides workers, by contract and for a fee, to work for a client but does not include a person who provides workers to a client on a temporary basis.

(b) "Temporary basis" means providing workers to a client for special situations such as to cover employee absences, employee leaves, professional skill shortages, seasonal workloads and special assignments and projects with the expectation that the position or positions will be terminated upon completion of the special situation. Workers also are provided on a temporary basis if they are provided as probationary new hires with a reasonable expectation of transitioning to per-

manent employment with the client and the client uses a preestablished probationary period in its overall employment selection program.

(c) "Temporary service provider" means a person who provides workers, by contract and for a fee, to a client on a temporary basis.

(2) No person shall perform services as a worker leasing company in this state without first having obtained a license therefor from the Director of the Department of Consumer and Business Services. No person required by this section to obtain a license shall fail to comply with this section or ORS 656.855, or any rule adopted pursuant thereto.

(3) When a worker leasing company provides workers to a client, the worker leasing company shall satisfy the requirements of ORS 656.017 and 656.407 and provide workers' compensation coverage for those workers and any subject workers employed by the client unless during the term of the lease arrangement the client has [*an active guaranty contract*] **proof of coverage** on file with the director that extends coverage to subject workers employed by the client and any workers leased by the client. If the client allows the [*guaranty contract to terminate*] **coverage to expire** and continues to employ subject workers or has leased workers, the client shall be considered a noncomplying employer unless the worker leasing company has complied with subsection (5) of this section.

(4) When a worker leasing company provides workers for a client, the worker leasing company shall assure that the client provides adequate training, supervision and instruction for those workers to meet the requirements of ORS chapter 654.

(5) When a worker leasing company provides subject workers to work for a client and also provides workers' compensation coverage for those workers, the worker leasing company shall notify the director in writing. The notification shall be given in such manner as the director may prescribe. A worker leasing company may terminate its obligation to provide workers' compensation coverage for workers provided to a client by giving to the client and the director written notice of the termination. A notice of termination shall state the effective date and hour of the termination, but the termination shall be effective not less than 30 days after the notice is received by the director. Notice to the client under this section shall be given by mail, addressed to the client at [*its*] **the client's** last-known address. If the client is a partnership, notice may be given to any of the partners. If the client is a corporation, notice may be given to any agent or officer of the corporation upon whom legal process may be served.

SECTION 21. ORS 654.097 is amended to read:

654.097. (1)(a) An insurer that [*issues guaranty contracts*] **provides workers' compensation coverage** to employers pursuant to ORS chapter 656 shall furnish occupational safety and health loss control consultative services to its insured employers in accordance with standards established by the Director of the Department of Consumer and Business Services.

(b) A self-insured employer shall establish and implement an occupational safety and health loss control program in accordance with standards established by the director.

(2) An insurer or self-insured employer may furnish any of the services required by this section through an independent contractor.

(3) The program of an insurer for furnishing loss control consultative services as required by this section shall be adequate to meet the minimum standards prescribed by the director by rule from time to time. Such services shall include the conduct of workplace surveys to identify health and safety problems, review of employer injury records with appropriate persons and development of plans for improvement of employer health and safety loss records. At the time a [*guaranty contract*] **workers' compensation insurance policy** is issued and on an annual basis thereafter, the insurer shall notify its insured employers of the loss control consultative services that the insurer is required by rule to offer, without additional charge as provided in this section, and shall provide a written description of the services that the insurer does offer.

(4) The insurer shall not charge any fee in addition to the insurance premium for safety and health loss control consultative services.

(5) Each insurer shall make available, at the request of the director and in the form prescribed by the director, its annual expenditures for safety and health loss control activities for the prior year and its budget for safety and health loss control activities for the following year.

(6) As used in this section, "employer," "insurer" and "self-insured employer" have the meaning for those terms provided in ORS 656.005.

SECTION 22. ORS 731.158 is amended to read:

731.158. "Casualty insurance" means:

(1) Insurance against legal, contractual or assumed liability for death, injury or disability of any human, or for damage to property; and provision for medical, hospital, surgical and disability benefits to injured persons including insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan and funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as coverage for personal injury protection benefits under a motor vehicle liability policy or as an incidental coverage with or supplemental to liability insurance;

(2) Motor vehicle physical damage, burglary and theft, glass, boiler and machinery, credit and livestock insurance;

(3) Insurance of the obligations accepted by, imposed upon or assumed by employers under law for death, disablement or occupational diseases of employees**;[***, including issuing guaranty contracts in connection therewith;*]

(4) Insurance which undertakes to perform or provide repair or replacement service or indemnification therefor for the operational or structural failure of specified real or personal property or property components; and

(5) Insurance against any other kind of loss, damage or liability properly a subject of insurance and not within any other class of insurance otherwise defined, if such insurance is not disapproved by the Director of the Department of Consumer and Business Services as being contrary to law or public policy.

SECTION 23. ORS 731.475 is amended to read:

731.475. (1) Every insurer authorized to issue workers' compensation coverage to subject employers as required by ORS chapter 656 shall maintain a place of business in this state where the insurer shall:

(a) Process, and keep complete records of, claims for compensation made to the insurer under ORS chapter 656.

(b) Make available upon request complete records, including all records submitted electronically, of all [*guaranty contracts*] **workers' compensation insurance policies** issued as required by ORS chapter 656.

(c) Keep records identifying the specific persons covered by an employer electing coverage pursuant to ORS 656.039.

(2) Claims records must be retained in, and may be removed from, this state or disposed of, in accordance with the rules of the Director of the Department of Consumer and Business Services. The records must be available to the Department of Consumer and Business Services for examination and audit at all reasonable times upon notice by the department to the insurer.

(3) In lieu of establishing a place of business in this state for the purpose required by this section, an insurer may keep such records in this state at places of business operated by service companies, if:

(a) Each service company is incorporated in or authorized to do business in this state;

(b) The agreement entered into between the insurer and the service company grants each service company a power of attorney to act for the insurer in workers' compensation coverage and claims proceedings under ORS chapter 656; and

(c) The agreement entered into between the insurer and each service company is approved by the director.

(4) Notwithstanding subsection (3) of this section, an insurer may not:

(a) Enter into a service agreement contract with one of its insureds unless the insured has service contracts with other insurers; or

(b) Have more than eight locations at any one time where claims are processed or records are maintained.

SECTION 24. ORS 731.480 is amended to read:

731.480. An insurer shall not issue [*guaranty contracts*] **workers' compensation insurance policies** pursuant to ORS chapter 656 unless it furnishes occupational safety and health loss control consultative services to its insured employers consistent with the requirements of ORS 654.097.

SECTION 25. ORS 731.590 is amended to read:

731.590. As used in ORS 731.592 and 731.594, "insurer" includes, but is not limited to:

(1) An insurer, as defined in ORS 731.106.

(2) A health care service contractor, as defined in ORS 750.005, including, but not limited to, a health maintenance organization.

(3) A multiple employer welfare arrangement, as defined in ORS 750.301.

(4) A legal entity that is self-insured and provides insurance services to its employees.

(5) [*A guaranty contract*] **An** insurer, as defined in ORS 656.005.

(6) An employer authorized under ORS chapter 656 to self-insure its workers' compensation risk.

(7) A fraternal benefit society, as described in ORS 748.106.

(8) An insurance producer, as defined in ORS 731.104.

SECTION 26. ORS 731.608 is amended to read:

731.608. (1) Except as provided in subsection (2) of this section, deposits made in this state under ORS 731.624 shall be held for the faithful performance by the insurer of all insurance obligations, including claims for unearned premiums, with respect to domestic risks pertaining to the particular class of insurance for which the deposit was made. However, there shall be excluded from each such obligation the same amount as is excluded in determining the obligation of the Oregon Insurance Guaranty Association under ORS 734.510 to 734.710.

(2) If at any time a deposit made under ORS 731.624 by a particular insurer is insufficient to perform the insurance obligations upon the faithful performance of which the deposit was conditioned, then any other deposit made under ORS 731.624 by that insurer shall be so used to the extent that such other deposit is not used to perform the insurance obligations upon the faithful performance of which such other deposit was conditioned.

(3) Deposits made by insurers and reinsurers in this state under ORS 731.628 shall be held for the payment of compensation benefits to workers employed by insured employers other than those insured with the State Accident Insurance Fund Corporation to whom the insurer has issued a [*guaranty contract*] **workers' compensation insurance policy** under ORS chapter 656. Deposits made by insurers and reinsurers under ORS 731.628 also shall be held to reimburse the Department of Consumer and Business Services, subject to approval by the Director of the Department of Consumer and Business Services, for costs incurred by the department in processing workers' compensation claims of insurers which have been placed in liquidation, receivership, rehabilitation or other such status for the orderly conservation or distribution of assets, pursuant to the laws of this state or any other state.

(4) A deposit made in this state by a domestic insurer transacting insurance in another jurisdiction, and as required by the laws of such jurisdiction, shall be held for the purpose or purposes required by such laws.

(5) Deposits of foreign and alien insurers required pursuant to ORS 731.854 shall be held for such purposes as are required by such law, and as specified by the director's order by which the deposit is required.

(6) Deposits of domestic reciprocal insurers required pursuant to ORS 731.632 shall be held for the benefit of subscribers wherever located.

SECTION 27. ORS 731.628 is amended to read:

731.628. (1) In addition to any other requirement therefor under the Insurance Code, each insurer other than the State Accident Insurance Fund Corporation that issues [*guaranty contracts*]

workers' compensation insurance policies to employers under ORS chapter 656 shall deposit with the Department of Consumer and Business Services an amount that is the greater of the following amounts:

(a) $100,000.

(b) An amount equal to the sum described in this paragraph less credits for approved reinsurance that the insurer may take under subsection (2) of this section. The sum under this paragraph is the sum of the following, computed as of December 31 next preceding in respect to [*guaranty contracts*] **workers' compensation insurance policies** written subject to ORS chapter 656:

(A) The aggregate of the present values at four percent interest of the determined and estimated future loss and loss-expense payments upon claims incurred more than three years next preceding the date of computation.

(B) The aggregate of the amounts computed under this subparagraph for each of the three years next preceding the date of computation. The amount for each year shall be 65 percent of the earned premiums for the year less all loss and loss-expense payments made upon claims incurred in the corresponding year, except that the amount for any year shall not be less than the present value at four percent interest of the determined and estimated future loss and loss-expense payments upon claims incurred in that year.

(2) Before an insurer may take a credit for reinsurance under subsection (1)(b) of this section, the reinsurer must deposit with the department an amount equal to the credit to be taken.

(3) An insurer may be allowed the credit referred to in subsection (1)(b) of this section only when the reinsurer has deposited with the department an amount equal to the credit.

SECTION 28. ORS 737.602 is amended to read:

737.602. (1) As used in this section:

(a) "Project" means a construction project, a plant expansion or improvements within Oregon with an aggregate construction value in excess of $90 million that is to be completed within a defined period. The average construction value during the defined period of the project must be at least $18 million per year. "Project" does not mean a series of unrelated construction projects artificially aggregated to satisfy the $90 million requirement.

(b) "Project sponsor" means public bodies, utilities, corporations and firms undertaking to construct a project in excess of $90 million and conducting business in the State of Oregon.

(c) "Public body" has the meaning given the term in ORS 30.260.

(2) Notwithstanding ORS 279C.530, 656.126, 737.600 or 746.160, an insurer approved to transact insurance in this state, including the State Accident Insurance Fund Corporation or [*a guaranty contract*] **an** insurer as defined in ORS 656.005, may issue with the prior approval of the Director of the Department of Consumer and Business Services a policy of insurance [*or a guaranty contract covering and insuring*] **covering** the project sponsor, the prime contractor under a contract for the construction of the project, any contractors or subcontractors with whom the prime contractor may enter into contracts for the purpose of fulfilling its contractual obligations in construction of the project and any other contractors engaged by a project sponsor to provide architectural or other design services, engineering services, construction management services, other consulting services relating to the design and construction of the project or any combination thereof.

(3) The following provisions apply to premiums under a policy of insurance [*or guaranty contract*] described in subsection (2) of this section:

(a) A project sponsor or a prime contractor may not charge a premium for coverage under a policy of insurance [*or a guaranty contract*] to a contractor or subcontractor with whom the project sponsor or prime contractor enters into a contract or engages for services described in subsection (2) of this section.

(b) A prime contractor may not charge a project sponsor a premium for coverage under a policy of insurance [*or a guaranty contract*] other than a premium approved by the director under ORS chapter 737 prior to or at the same time as the director approves the project to which the policy [*or guaranty contract*] applies.

(c) Charging a premium prohibited by this subsection constitutes the unlawful transaction of insurance in violation of ORS 731.354.

(4) The director, upon application of any insurer, shall approve the issuance of a policy of insurance [*or a guaranty contract*] to any grouping of the persons described in subsection (2) of this section if:

(a) The grouping was formed for the purpose of performing a contract or a series of related contracts for the design and construction of a project for the project sponsor;

(b) The project sponsor can reasonably demonstrate that the formation and operation of the grouping will substantially improve accident prevention and claims handling to the benefit of the project sponsor and the contractors and workers employed by the project sponsor on construction related projects;

(c) The established rating and auditing standards required by authorized advisory organizations and rating organizations are adhered to;

(d) The insurer for the grouping guarantees adequate protection to any other insurance producer that demonstrates that without such protection the producer will suffer losses that will constitute a threat to the continuation of the business of the producer;

(e) The insurer for the grouping guarantees insurance coverage of the classes of insurance issued to the grouping to any contractor who, because of participation in the group, has been unable to maintain the contractor′s normal coverage. The insurer′s obligation under this paragraph shall continue until 12 months after substantial completion of the contractor′s work;

(f) By permitting this grouping for a project sponsor, greater opportunities will be made available for historically underutilized businesses to bid on the project;

(g) The project insurers agree to provide not less than 90 days′ notice to all insured parties of the cancellation or any material reduction in coverage for the project;

(h) The insurance coverage for the grouping contains a severability of interest clause with respect to liability claims between individuals insured under the group policy and includes contractual liability coverage that applies to the various contracts and subcontracts entered into in connection with the project; and

(i) The insurer places with the Department of Consumer and Business Services a special deposit of $25,000 per $100 million of construction project value, or an amount prescribed by rule of the director, whichever is greater.

SECTION 29. ORS 746.145 is amended to read:

746.145. (1) Notwithstanding ORS 737.600, but subject to all other rate filing requirements of ORS chapter 737, an insurer may combine for dividend purposes the experience of a group of employers covered for workers′ compensation insurance by the insurer, subject to applicable rules adopted by the Director of the Department of Consumer and Business Services, if:

(a) All the employers in the group are members of an organization.

(b) The employers in the group constitute at least 50 percent of the employers in the organization, unless the number of covered workers in the group exceeds 500, in which case the employers in the group must constitute at least 25 percent of the employers in the organization.

(c) The grouping of employers is likely to substantially improve accident prevention, claims handling for the employers and reduce expenses.

(2) This section does not apply to an organization of employers for which organization a workers′ compensation policy was lawfully issued before October 4, 1977. The [*guaranty contract*] **policy** required by ORS 656.419 shall contain for each employer covered thereby the information required by ORS 656.419 (2). When an employer becomes an insured member of the organization the insurer shall, within 30 days after the date insured membership commenced, file a notice thereof with the director.

SECTION 30. ORS 656.440 is amended to read:

656.440. (1) Before revocation of certification under ORS 656.434 becomes effective, the Director of the Department of Consumer and Business Services shall give the employer notice that the certification will be revoked stating the grounds for the revocation. The notice shall be served on the

employer in the manner provided by ORS 656.427 [*(3)*] **(4)**. The revocation shall become effective within 10 days after receipt of such notice by the employer unless within such period of time the employer corrects the grounds for the revocation or appeals in writing to the director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge.

(2) If the employer appeals, the Hearings Division of the Workers' Compensation Board under ORS 656.283 shall set a date for a hearing, which date shall be within 30 days after receiving the appeal request, and shall give the employer at least five days' notice of the time and place of the hearing. A record of the hearing shall be kept but it need not be transcribed unless requested by the employer. The cost of transcription shall be charged to the employer. Within 10 days after the hearing, the Administrative Law Judge shall either affirm or disaffirm the revocation and give the employer written notice thereof by registered or certified mail.

(3) If revocation is affirmed on review by the Administrative Law Judge, the revocation is effective five days after the employer receives notice of the affirmance unless within such period of time the employer corrects the grounds for the revocation or petitions for judicial review of the affirmance pursuant to ORS 183.480 to 183.497.

(4) If the revocation is affirmed following judicial review, the revocation is effective five days after entry of the final judgment of affirmance, unless within such period the employer corrects the grounds for the revocation.

SECTION 31. Except as provided in section 32 of this 2007 Act, the amendments to ORS 654.097, 656.005, 656.039, 656.128, 656.210, 656.268, 656.407, 656.419, 656.423, 656.427, 656.440, 656.443, 656.447, 656.622, 656.628, 656.726, 656.730, 656.740, 656.850, 731.158, 731.475, 731.480, 731.590, 731.608, 731.628, 737.602 and 746.145 by sections 1 to 30 of this 2007 Act become operative on July 1, 2009.

SECTION 32. The Director of the Department of Consumer and Business Services may take any action before the operative date of this 2007 Act that is necessary to enable the director to exercise, on and after the operative date of this 2007 Act, all the duties, functions and powers conferred on the director by this 2007 Act.

Passed by Senate April 16, 2007

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Secretary of Senate

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President of Senate

Passed by House May 10, 2007

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Speaker of House

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

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Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

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Secretary of State