Senate Bill 110

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Modifies scope of benefits paid in workers' compensation death claims.

A BILL FOR AN ACT

Relating to death benefits paid in workers' compensation claims; amending ORS 656.204, 656.218 and 656.262.

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

SECTION 1. ORS 656.204 is amended to read:

656.204. If death results from the accidental injury, payments shall be made as follows:

(1)**(a)** The cost of [*burial*] **final disposition of the body and funeral expenses**, including **but not limited to** transportation of the body, shall be paid, not to exceed [*10*] **20** times the average weekly wage in any case.

(b) The insurer or self-insured employer shall pay bills submitted for disposition and funeral expenses up to the benefit limit established in paragraph (a) of this subsection. If any part of the benefit remains unpaid 60 days after claim acceptance, the insurer or self-insured employer shall pay the unpaid amount to the estate of the worker.

(2)(a) If the worker is survived by a spouse, monthly benefits shall be paid in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs.

(b) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 10 percent of the average weekly wage for each child of the deceased who is substantially dependent on the spouse for support, until such child becomes 18 years of age.

(c) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 25 percent of the average weekly wage for each child of the deceased who is not substantially dependent on the spouse for support, until such child becomes 18 years of age.

(d) If a surviving spouse receiving monthly payments dies, leaving a child who is entitled to compensation on account of the death of the worker, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age or the child's entitlement to benefits under subsection (8) of this section ceases, whichever is later.

(e) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(f) In no event shall the total monthly benefits provided for in this subsection exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this max-

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

imum, the benefit for each child will be reduced proportionally.

(3)(a) Upon remarriage, a surviving spouse shall be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payments for each child shall continue as before.

(b) If, after the date of the subject worker's death, the surviving spouse cohabits with another person for an aggregate period of more than one year and a child has resulted from the relationship, the surviving spouse shall be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payment for any child who is entitled to compensation on account of the death of the worker shall continue as before.

(4)(a) If the worker leaves neither wife nor husband, but a child under 18 years of age, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age.

(b) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(c) In no event shall the total benefits provided for in this subsection exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child will be reduced proportionally.

(5)(a) If the worker leaves a dependent other than a surviving spouse or a child, a monthly payment shall be made to each dependent equal to 50 percent of the average monthly support actually received by such dependent from the worker during the 12 months next preceding the occurrence of the accidental injury. If a dependent is under the age of 18 years at the time of the accidental injury, the payment to the dependent shall cease when such dependent becomes 18 years of age. The payment to any dependent shall cease under the same circumstances that would have terminated the dependency had the injury not happened.

(b) If the dependent who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(c) In no event shall the total benefits provided for in this subsection exceed 4.35 times 10 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each dependent will be reduced proportionally.

(6) If a child is an invalid at the time the child otherwise becomes ineligible for benefits under this section, the payment to the child shall continue while the child remains an invalid. If a person is entitled to payment because the person is an invalid, payment shall terminate when the person ceases to be an invalid.

(7) If, at the time of the death of a worker, the child of the worker or dependent has become 17 years of age but is under 18 years of age, the child or dependent shall receive the payment provided in this section for a period of one year from the date of the death. However, if after such period the child is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(8)(a) Benefits under this section which are to be paid as provided in this subsection shall be paid for the child or dependent until the child or dependent becomes 19 years of age. If, however, the child or dependent is attending higher education or begins attending higher education within six months of the date the child or dependent leaves high school, benefits shall be paid until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier.

(b) If a child or dependent who is eligible for benefits under this subsection has no surviving parent, the child or dependent shall receive 4.35 times 66-2/3 percent of the average

weekly wage until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier.

[*(b)*] **(c)** As used in this subsection, "attending higher education" means regularly attending community college, college or university, or regularly attending a course of vocational or technical training designed to prepare the participant for gainful employment. A child or dependent enrolled in an educational course load of less than one-half of that determined by the educational facility to constitute "full-time" enrollment is not "attending higher education."

(9) As used in this section, "average weekly wage" has the meaning for that term provided in ORS 656.211.

SECTION 2. ORS 656.218 is amended to read:

656.218. (1) In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof have been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.

(2) If the worker's death occurs prior to issuance of a notice of closure under ORS 656.268, the insurer or the self-insured employer shall determine compensation for permanent partial disability, if any.

(3) If the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing.

(4) If the worker dies before filing a request for hearing, the persons described in subsection (5) of this section shall be entitled to file a request for hearing and to pursue the matter to final determination as to all issues presented by the request for hearing.

(5) The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, [*a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204*] **the unpaid balance of the award shall be paid to the worker's estate**.

(6) This section does not entitle any person to double payments on account of the death of a worker and a continuation of payments for permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

SECTION 3. ORS 656.262 is amended to read:

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

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

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

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

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

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

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

(E) Any other details the insurer may require.

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

(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where the Director of the Department of Consumer and Business Services determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

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

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

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

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

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

(g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 ceases to authorize temporary disability or for any period of time not authorized by the attending physician or nurse practitioner. No authorization of temporary disability

compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance.

(h) The worker's disability may be authorized only by a person described in ORS 656.005 (12)(b)(B) or 656.245 for the period of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend payment of temporary disability benefits to the worker at the expiration of the period until temporary disability is reauthorized by an attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245.

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

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

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

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

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-

ceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or [*burial*] **funeral** expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

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

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

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

(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

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

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

(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

(b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause

of the worker's combined condition before the claim may be closed.

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of acceptance or denial to the noncomplying employer.

(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319.

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

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be proportionate to the benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $2,000 absent a showing of extraordinary circumstances. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

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

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

(13) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. However, if the attorney

is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

(14) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim.

(15) In accordance with ORS 656.283 (4), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (13) of this section.
