BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of:	)	
OAR 436-050, Employer/Insurer Coverage Responsibility	)	SUMMARY OF
	)	TESTIMONY AND
	)	AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency's conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated Oct. 1, 2017. On Oct. 20, 2017, a public rulemaking hearing was held as announced at 9:30 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. The record was held open for written comment through Oct. 26, 2017.

One person testified about proposed changes to OAR 436-050 at the public rulemaking hearing, recorded below as Exhibit 3. Written testimony is also listed below.

Testimony list:

Exhibit	Testifying
1	Claire Hertz, Beaverton School District | Mary Knigge, North Clackamas School District | Sarah Head, Salem-Keizer Public Schools
2	Jason Cupp, Workers' Compensation Division
3	Hearing transcript - Claire Hertz, Beaverton School District

Testimony: OAR 436-050-0150 ***Exhibits 1 and 3***

Exh. 1 – "We propose the following changes to the proposed amendments to 436-050-0150, as noted below.

> **(4)- Financial Strength Analysis:**
>
> (c) The director will score the financial strength of an employer that is a municipal corporation as defined in ORS 297.405 that submits an audited ~~Comprehensive~~ Annual Financial Report, based on the following ratios:
>
> (A) The **current ratio** is calculated by dividing current assets by current liabilities ~~plus deferred outflows~~.
> (B) The **debt service ratio** is calculated by dividing total annual debt service by total annual revenue.
> (C) The return-on-net assets ratio is calculated by dividing the sum of net income plus the income effect of the changes in pension obligations by the sum of net assets plus net pension liability. For fiscal years beginning after June 15, 2017 the return on net assets ratio is calculated by dividing sum of net income plus the income effect of the changes in pension and OPEB obligations by the sum of net assets plus net pension and OPEB liabilities.
>
> **(6) Financial strength based on municipal bond ratings.**
>
> Notwithstanding section (5) of this rule, a public self-insured employer with a municipal bond rating of ~~Aa3, AA~~ A3, A-, or higher will be considered to have a strong financial strength rating.

Exh. 1* – "The proposed change to (4) (c) is needed because not all government entities file a Comprehensive Annual Financial Report (CAFR) because of the additional cost and complexity associated with preparing a CAFR. The numbers needed to calculate the financial strength ratios should be available from an audited financial report, and requiring a CAFR may needlessly cause some entities to fail the ratio tests."
*consistent with Exh. 3

Exh. 3 – "* * * having that language and that requirement is outside of the scope of the smaller school districts."

Response: The division recognizes that not all governmental entities file a Comprehensive Annual Financial Report (CAFR); however, to ensure that ratios are calculated in a consistent manner, we believe that the rule is appropriate as written. There are important differences between the standards and formatting requirements that apply to CAFRs and those that apply to other annual financial reports. Certain information, such as information about debt structure and servicing, that is available in a CAFR may not be available in an annual financial report or may be reported using different assumptions that can impact the calculation of the ratio. We do want to note that the rule does not require a public self-insured employer to submit a CAFR. If financial reports are submitted in a different format, the employer will be subject to the same ratio tests as other self-insured employers under OAR 436-050-0150(4)(b). If an employer receives a moderate or weak rating, the division will consider if additional actions are appropriate on a case-by-cases basis.

Exh. 1 – "The proposed change to (4)(c)(A) is needed because deferred outflows are substantially not related to current commitments or liabilities, and will not be reflected in expenses in the next year. For financial reporting, "current" is defined as an asset providing resources or liability requiring the use of resources, which will be available (or used) within one year. Two common examples of deferred outflows are pension deferrals and deferred bond refunding losses. Pension deferrals are commonly amortized over five years, and bond refunding losses are typically amortized over much longer periods.

"As an example, the **current ratio** for North Clackamas School District for the year ended June

30, 2016 calculated including and excluding deferred outflows is as follows:

"Current Assets $56.5M / [Current Liabilities $41.0M + Deferred Outflows $39.7M] =.70

"Current Assets $56.5M / Current Liabilities $41.0M = 1.38

"Deferred Outflows in this example relate primarily to deferred loss on bond refunding, which is being amortized through 2031 and is substantially non-current.

"The ratio calculation including deferred outflows is worth 0 points, and excluding deferred outflows is worth 2 points using DCBS' proposed scoring system."

Response: The division proposed the inclusion of deferred outflows because the timing of the outflow is not always clear. After consideration of the testimony, the division agrees that the inclusion of these amounts is not necessary to provide an accurate picture of an employer's ability to meet current obligations and may produce outcomes that are not consistent with the intent of the rule-change. The rule has been amended as suggested.

Exh. 1 – "The proposed change to (4)(c)(B) is recommended merely to provide clarification."

Response: The division believes that the proposed change is not necessary because debt service and revenue are typically reported on an annual basis.

Exh. 1 – "The proposed change to (4)(c)(C) is needed because a recent change in governmental accounting standards (GASB 68) now requires that future pension obligations be reported as a liability on the District's financial statements, regardless of how many years in the future this obligation is due. This has caused many governmental entities to report greatly increased Total Liabilities and greatly reduced or negative Net Position on the Statement of Net Position. These changes can significantly decrease **return on net assets ratio**, and provide a skewed picture of financial health. We propose that removing the pension liability and pension income effects from the **return on net assets ratio** calculation will provide a more accurate assessment of financial health. Additionally, a new accounting standard (GASB 75) is now in effect for financial statements beginning after June 15, 2017. This standard requires that future obligations related to post-employment benefits other than pensions (OPEB) be reported as a liability. We also propose a similar adjustment for the OPEB liability once this standard is used in financial reporting.

"As an example, the **return on net assets ratio** for North Clackamas School District for the year ended June 30, 2016 calculated including and excluding Net Pension Liability (NPL) and Pension Income Effects (PIE) is as follows (negative amounts shown in parentheses):

"Change in Net Position $(13.2M)/Net Position $11.2M = (118%)

"[Change in Net Position $(13.2M) + PIE $28.2M]/[Net Position $(13.2M)+NPL $31.1M] = 35%

"The ratio calculated including NPL and PIE is worth 0 points, and excluding NPL and PIE is worth 6 points using DCBS' proposed scoring system.

Response: The division recognizes that by requiring employers to report future pension obligations as liabilities, GASB 68 has had a negative impact on the financial strength rating of some public self-insured employers. While we recognize that the change in accounting standards did not create any new obligations, we believe the changes were made to provide a more comprehensive picture of the reporting entity's assets and liabilities, and that it may not be appropriate to exclude these values by rule. The division will continue to evaluate the impact of

changes in GASB standards on the reporting of liabilities related to pensions and other post-employment benefits on self-insured employers' financial strength ratings, and will determine whether additional adjustments are appropriate on a case-by-case basis.

Exh. 1 – "The proposed change to **(6) Financial strength based on municipal bond ratings** is needed because the criteria as stated exclude many entities with strong ratings. Ratings in the range of A1 to A3 or A+ to A- are considered strong, but are not included in the proposal. Without this change, many entities regarded as financially strong by external bond rating agencies and investors will not be considered strong by DCBS."

Response: Advice provided by Beaverton School Districts dated September 12, 2017, included a chart comparing ratings from Moody's, Standard and Poor's, and Fitch which described bond ratings in the range of A1 to A3 or A+ to A- as meaning "Upper Medium." We believe "upper medium" corresponds more closely to a "moderate" rating under our financial strength analysis. This rule was intended to allow public self-insured employers who are regarded as financially strong by external bond rating agencies to be considered to have a "strong" rating regardless of the outcome of our analysis. We believe that it is appropriate for a public self-insured employer that is rated below Aa3 or AA- to be subject to our analysis so that we may modify the employer's security deposit or take other actions as appropriate.

Testimony: OAR 436-050-0150 ***Exhibit 3***

"* * * for instance, North Clackamas and Beaverton have both Standard and Poor's and Moody's, and we would qualify under one of the ratings and not qualify under the other rating, so we're not sure if it just has to be one of the two * * *."

Response: The division acknowledges that the proposed rule did not clearly explain the outcome when a public employer is rated Aa3, AA- or better by one rating agency and lower by another. To resolve this issue, the rule has been amended to allow the public self-insured employer to choose what rating is used by providing evidence of its bond rating. While the division may verify the evidence, and review the ratings provided by other rating agencies, we will only consider the rating provided by the self-insured employer for the purposes of OAR 436-050-0150(6).

Testimony: OAR 436-050-0150 ***Exhibit 3***

"* * * not all of the school districts have [bond] ratings because not all school districts issue bonds, so just making sure that its not a requirement to have those ratings."

Response: The division does not intend for any rating by an external rating agency to be required for an employer to qualify as a self-insured employer. The rule provides an optional rating methodology for public self-insured employers with a municipal bond rating of Aa3, AA- or higher.

Testimony: OAR 436-050-0150 ***Exhibit 3***

"* * * we would really like to propose language that takes into account the PERS unfunded actuarial liability as well as future OPEB, other post employment benefit liabilities, from GASB rules that require us to post long term liability for things that we pay as we go basis, and * * * we would like to exclude that in the calculation of the financial rating of school districts. * * *"

Response: The division recognizes that by requiring employers to report future pension

obligations as liabilities, GASB 68 has had a negative impact on the financial strength rating of some public self-insured employers. While we recognize that the change in accounting standards did not create any new obligations, we believe the changes were made to provide a more comprehensive picture of the reporting entity's assets and liabilities, and that it may not be appropriate to exclude these values by rule. The division will continue to evaluate the impact of changes in GASB standards on the reporting of liabilities related to pensions and other post-employment benefits on self-insured employers' financial strength ratings, and will determine whether additional adjustments are appropriate on a case-by-case basis.

Testimony: OAR 436-050-0175(3)(a) ***Exhibit 2***

"* * * the word "maximum" from OAR 436-050-0175(3)(a)(C) should be removed. This paragraph currently requires self-insured employers to report the number of claims for which the maximum medical reimbursement amount is claimed. The preceding section, OAR 436-050-0175(3)(a)(B), already has a proposed amendment to remove the word "maximum" to require self-insured employers to report all medical reimbursement amounts to the director, including amounts below the maximum. A similar revision is needed in OAR 436-050-0175(3)(a)(C) to ensure that the number of claims reported includes all claims for which medical reimbursement is requested."

Response: The rules have been amended as suggested to ensure that medical reimbursements are consistently reported.

Testimony: OAR 436-050-0175(3)(b) ***Exhibit 2***

"* * * the division should remove the paragraph added to OAR 436-050-0175(3)(b), requiring self-insured employers to report the medical reimbursement amount per claim in the non-experience period. These previously reimbursed amounts are already reflected in the total paid losses reported for the claim. Because paid losses in the non-experience period do not affect the self-insured employer's experience rating, security deposit, or other amounts due, the division does not need this information to be reported in the annual report of losses. The requirement should be removed to avoid potential confusion or misinterpretation of how the reimbursements are applied in the non-experience period."

Response: The rules have been amended as suggested to ensure that medical reimbursements are consistently reported and to avoid potential confusion or misinterpretation of how the reimbursements are applied in the non-experience period.

Dated this 14th day of December, 2017.

Exhibit
"1"

MEMO

DATE: October 13, 2017

TO: Fred Bruyns, Department of Consumer and Business Services, Workers Compensation Division

FROM: Claire Hertz, Chief Financial Officer, Beaverton School District

Mary Knigge, Chief Financial Officer, North Clackamas School District

Sarah Head, Director of Budget and Financial Services, Salem-Keizer Public Schools

RE: Response to proposed amendments to OAR 436-050-0150

This memo is in response to proposed amendments to OAR 436-050-0150 filed by DCBS on September 15, 2017. We propose the following changes to the proposed amendments to 436-050-0150, as noted below.

(4)- Financial Strength Analysis:

(c) The director will score the financial strength of an employer that is a municipal corporation as defined in ORS 297.405 that submits an audited ~~Comprehensive~~ Annual Financial Report, based on the following ratios:

(A) The **current ratio** is calculated by dividing current assets by current liabilities ~~plus deferred outflows~~.
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(6) Financial strength based on municipal bond ratings.

Notwithstanding section (5) of this rule, a public self-insured employer with a municipal bond rating of ~~Aa3, AA-~~ A3, A-, or higher will be considered to have a strong financial strength rating.

The proposed change to (4) (c) is needed because not all government entities file a Comprehensive Annual Financial Report (CAFR) because of the additional cost and complexity associated with preparing a CAFR. The numbers needed to calculate the financial strength ratios should be available from an audited financial report, and requiring a CAFR may needlessly cause some entities to fail the ratio tests.

The proposed change to (4)(c)(A) is needed because deferred outflows are substantially not related to current commitments or liabilities, and will not be reflected in expenses in the next year. For financial reporting, "current" is defined as an asset providing resources or liability requiring the use of resources, which will be available (or used) within one year. Two common examples of deferred outflows are pension deferrals and deferred bond refunding losses. Pension deferrals are commonly amortized over five years, and bond refunding losses are typically amortized over much longer periods.

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The ratio calculation including deferred outflows is worth 0 points, and excluding deferred outflows is worth 2 points using DCBS' proposed scoring system.

The proposed change to (4)(c)(B) is recommended merely to provide clarification.

The proposed change to (4)(c)(C) is needed because a recent change in governmental accounting standards (GASB 68) now requires that future pension obligations be reported as a liability on the District's financial statements, regardless of how many years in the future this obligation is due. This has caused many governmental entities to report greatly increased Total Liabilities and greatly reduced or negative Net Position on the Statement of Net Position. These changes can significantly decrease **return on net assets ratio**, and provide a skewed picture of financial health. We propose that removing the pension liability and pension income effects from the **return on net assets ratio** calculation will provide a more accurate assessment of financial health. Additionally, a new accounting standard (GASB 75) is now in effect for financial statements beginning after June 15, 2017. This standard requires that future obligations related to post-employment benefits other than pensions (OPEB) be reported as a liability. We also propose a similar adjustment for the OPEB liability once this standard is used in financial reporting.

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The proposed change to **(6) Financial strength based on municipal bond ratings** is needed because the criteria as stated exclude many entities with strong ratings. Ratings in the range of A1 to A3 or A+ to A- are considered strong, but are not included in the proposal. Without this change, many entities regarded as financially strong by external bond rating agencies and investors will not be considered strong by DCBS.

We appreciate your willingness to work with us to develop more meaningful methods of evaluation for school districts and other governmental entities. We would welcome further conversation before this proposal is finalized.

Exhibit
"2"

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

MEMORANDUM

10/10/2017

To: Fred Bruyns, Rules Coordinator

CC: Barbra Hall, SIRR Manager
Adam Breitenstein, Performance Manager
Lou Savage, Administrator

From: Jason Cupp, Self-Insurance Auditor

Subject: Proposed rule changes affecting OAR 436-050

Issue

In order to implement House Bills 2186 and 2336 (2017), the Workers' Compensation Division proposed rule changes to OAR 436-050 and scheduled a public hearing for October 20, 2017. A review by staff in the affected program area has generated additional suggestions.

This memo constitutes staff testimony that will be entered into the record.

Recommendations

First, the word "maximum" from OAR 436-050-0175(3)(a)(C) should be removed. This paragraph currently requires self-insured employers to report the number of claims for which the maximum medical reimbursement amount is claimed. The preceding section, OAR 436-050-0175(3)(a)(B), already has a proposed amendment to remove the word "maximum" to require self-insured employers to report all medical reimbursement amounts to the director, including amounts below the maximum. A similar revision is needed in OAR 436-050-0175(3)(a)(C) to ensure that the number of claims reported includes all claims for which medical reimbursement is requested.

Next, the division should remove the paragraph added to OAR 436-050-0175(3)(b), requiring self-insured employers to report the medical reimbursement amount per claim in the non-experience period. These previously reimbursed amounts are already reflected in the total paid losses reported for the claim. Because paid losses in the non-experience period do not affect the self-insured employer's experience rating, security deposit, or other amounts due, the division does not need this information to be reported in the annual report of losses. The requirement should be removed to avoid potential confusion or misinterpretation of how the reimbursements are applied in the non-experience period.

BEFORE THE DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES OF THE STATE OF OREGON

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR: 436-010, Medical Services 436-050, Employer/Insurer Coverage Responsibility 436-060, Claims Administration 436-075, Retroactive Program	)))))	TRANSCRIPT OF TESTIMONY

The proposed amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated Oct. 1, 2017. On Oct. 20, 2017, a public rulemaking hearing was held as announced at 9:30 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. The record will be held open for written comment through Oct. 26, 2017.

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TRANSCRIPT OF PROCEEDINGS

Fred Bruyns: Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns , and I'll be the presiding officer for the hearing. The time is now 9:31 a.m. on Friday October 20, 2017.We are in Room F of the Labor & Industries Building, 350 Winter St. NE, in Salem, Oregon. We are making an audio recording of today's hearing. If you wish to present oral testimony today, please sign in on the "Testimony Sign-In Sheet." It's on the table by the entrance.

The Department of Consumer and Business Services, Workers' Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically: division 010, Medical Services; division 050, Employer/Insurer Coverage Responsibility, division 060, Claims Administration, and division 075, Retroactive Program. The department has summarized the proposed rule changes in the Notices of Proposed Rulemaking Hearing. These hearing notices, Statements of Need and Fiscal Impact, and proposed rules with marked changes, are on the table by the entrance. Public testimony is available on the division's website. The Workers' Compensation Division filed the Notices of Proposed Rulemaking and Statements of Need and Fiscal Impact with the Oregon Secretary of State on Sept. 15, 2017, mailed the Notices and Statements to its postal and electronic mailing lists; notified Oregon Legislators as required by ORS chapter 183; and posted public notice and the proposed rules to its website. The Oregon

Secretary of State published the hearing notices in its Oregon Bulletin dated Oct. 1, 2017. This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Oct. 26, 2017, and will make no decisions until all of the testimony is considered. We are ready to receive testimony. If you are reading from written testimony and give the agency a copy of that testimony, we will add it to the rulemaking record.

Kevin Anderson – could you come up and testify?

Kevin Anderson: Thanks Fred. For the record my name's Kevin Anderson. I'm an attorney at Sather Byerly, and Holloway. We represent employers and insurance companies in Oregon and in Washington. My testimony should be pretty brief. It's limited to just the changes to the WRME issue. I know during some of the discussions from MLAC, and kind of getting to the point of drafting these rules, people had kind of made a mental shortcut of saying the rule changes to mean that if the doctor doesn't respond to the IME, it means that they disagree with the IME, and I kind of want to make sure the record is clear on that, and I think these rules are clear. The doctor's failure to respond entitles the worker to a WRME, but it doesn't necessarily have any implication about what that attending physician thinks about that IME report. And I think the rules are clear, but if these go into effect I'd also like the division to kind of think about that when they're crafting the orders saying that the worker can get the WRME, of just saying the doctor did not respond and therefore is entitled, as opposed to - disagreed with the report or failed to respond and therefore we think they disagree, or something like that.

A couple other issues came up in just talking about the WRME process generally with some of my colleagues. Again, there's not a lot of WRME cases each year, so our sample size is a little small. But, we have had some cases where the division finds the worker eligible for a WRME, but either the exam never gets scheduled, it gets scheduled and they fail to appear, or it gets scheduled, they see who the doctor is, and then they kind of give up on the process; and we would like to see some sort of, I don't know, enforcement mechanism to actually, I don't know – compelled is the right word, but to keep the process going, either if the worker has a WRME and fails to show up, either it waves their right for further exams, or like with a missed IME, could result in a, you know, $100 penalty, or something like that.

And, the last point that I wanted to clarify was the – there's already the rule that says the insurer must forward the IME, and I think in these proposed rules it was moving it to a different section as well. I wanted to make sure that the insurer's obligations can be met if their agent, their attorney, or even the IME company themselves forwards the IME report to the attending physician. I could see an argument being made that – yes in fact the IME report was forwarded to the attending physician but it wasn't done by the insurer, and therefore that rule wasn't met – and so I just kind of would like some clarification and make sure that, you know, if I forward it on behalf of my client that meets my client's obligation.

Otherwise, I think the rules meet kind of goals of MLAC to try and change this – put the burden more on the insurance company to follow up with the attending physician, and make the WRME more accessible for workers in the process. Thanks.

Fred Bruyns: Thank you very much Kevin. Ted Heus?

Ted Heus: Alright, for the record, my name is Ted Heus. I am an attorney with Preston Bunnell. We represent injured workers, and represent injured workers before the agency and the Workers' Compensation Board and the Oregon Courts.

So I've reviewed the proposed changes to OAR 436-060-0147, the rules covering the eligibility criteria for approval of a worker-requested medical examination or WRMEs. I have several concerns about the language that the department chose. But two of them really stand out and need to be addressed by revision to the proposed rule language.

ORS 656.325(1)(e) is designed to allow workers access to a state appointed medical examination unless their attending physician agrees with an IME report, upon which a denial is based. However, the Workers' Compensation Division has interpreted the law to allow a full WRME only when the attending physician affirmatively disagrees with an IME report. Such an interpretation resulted in denials of WRMEs when the physician neither agrees nor disagrees or is silent on the IME report. There's a range of issues as to why an attending physician may fail to comment on an IME. Some of them, but not all of them, just the ones I've personally encountered, are that: insurers don't send IME reports to the attending physician; insurers send the report but don' ask for a comment, so the IME report ends up in the doctor's record but is never brought to the attending physician's attention; the attending physician might not be familiar with workers' compensation issues – causation or specific conditions – and desires not to get directly involved in the issue; the attending physician may feel that she or he lacks the medical expertise required to the IME, which is usually conducted by a medical specialist; the attending physician might charge to review records or comment on the report, and workers might not have the means to pay out of pocket fees for those comments and reviews and those are not generally covered by insurance; there may be other legal barriers to the attending physician commenting, such as federal laws prohibiting federally employed physicians, such as Veteran's Affairs' physicians, from getting involved in state workers' compensation litigation; finally, the attending physician may simply be unavailable for comment within the period that comment is sought.

After several litigations and bringing the issue to the attention of Management-Labor Advisory Committee, the Workers' Compensation Division agreed to act by amending the rule regarding WRME eligibility. However, the proposed amendments originally intended to resolve the problem of silence or nonresponse, doesn't actually solve the problem. Specifically, the proposed rule retains the "does not concur" language that caused all the confusion to begin with. And, the proposed language attempts to resolve the issue with an evidentiary workaround that frankly might exceed the Workers' Compensation Division's authority, depending on how that issue becomes litigated. Alright, so first and foremost, the problem is that the proposed rule doesn't actually change the phrase "does not concur," which is the statutory phrase, or phrase used in the statute. For years, and I don't know how many years, but as long as I've been litigating the issue, the Workers' Compensation Division has misinterpreted the statutory phrase to mean a physician's affirmative disagreement with an IME report or an affirmative nonconcurrence. This is shown both in its rulemaking, its decision making, its resistance to change the policy in the face of judge orders interpreting the statute differently, and has never actually formally recanted

its prior interpretation despite MLAC's recommendation for it to change the rule to fit the correct statutory interpretation. By retaining that language and having no written explanation of its meaning or interpretation, it appears the division continues to hold on to this interpretation, which means that WRMEs can be denied for the same reasons they always have if there is no evidence the attending physician affirmatively disagreed with the report. Instead, the division's added some provisions regarding what documentation is necessary to find a worker eligible. These are the proposed revisions under 436-060-0147(2)(b) – ah (a) and (b). However, those provisions are nothing more than an evidentiary workaround and they actually support the notion that the division continues to interpret "does not concur" language as meaning affirmative disagreement with an IME. The first provision provides that the worker is eligible for a WRME if he or the insurer produces documents to demonstrate the attending physician quote "does not concur." This is similar to the same requirement that existed prior to the rule provision changes. The WCD has previously held the position that it is impossible to produce [inaudible] documents demonstrating the physician's silence or refusal to comment [inaudible] you can't document silence. Prior to the changes, the division attempted to use this documentation requirement as an affirmative method to disapprove WRMEs in which there was no affirmative disagreement, proof of affirmative disagreement with a WRME. So, the division added the second provision: subsection (2)(b)(B) that establishes a default rule that determines the claimant is eligible for an examination if neither party produces evidence that the AP, sorry, attending physician does not concur with the IME – sorry – does or does not concur with the IME. You know, at first glance, this seems to cover the situations in which there's no evidence of an affirmative concurrence or nonconcurrence, affirmative disagreement or non – or affirmative disagreement – except that, if the division continues to interpret "does not concur" in a binary way, meaning either an affirmative disagreement or affirmative agreement, as the two potential results of an opinion or a response to an IME, then the documentation rules actually shift the burden of production to the employer, which I think exceeds the division's authority to do so the way. The way the statute is written, the claimant is the one who requested the IME and usually is the proponent of the IME and therefore bears the burden of proving what the statute requires. If the division continues to interpret the statutory phrase "does not concur" as binary, meaning is either met by affirmative disagreement or defeated by affirmative agreement, then it is the claimant's burden to establish affirmative disagreement to obtain the WRME. In contrast, if "does not concur" means one of three possibilities, like it should, like it's properly interpreted – either affirmative disagreement, affirmative agreement, or silence, then the claimant wins if he proves one of two possibilities, affirmative disagreement or lack of affirmative agreement. Subsection (2)(b)(B) essentially provides if there is no evidence on the question, then claimant wins. That is backwards if the division still adopts a binary approach to the phrase "does not concur." It places the burden on the employers to prove an affirmative concurrence. If the division adopts the correct meaning of the phrase "does not concur" means three possibilities, then the burden is not shifted, and only requires the insurer to disprove what is alleged by the claimant, that the AP has neither agreed nor disagreed with the IME. The problem is that the division has consistently and historically adopted the binary interpretation, and nothing in this rule or elsewhere suggests that it has changed its historical position on its interpretation of the phrase "does not concur."

Based on the above, I ask that the division revise its language to make clear that only an affirmative agreement with the IME acts as a bar to a WRME. The written comments that I've submitted to the division provide some suggested language to make that happen. Alternatively,

there needs to be some written record of the division's intent in changing the rule. Since it appears nowhere in the rule, I request the administrator go on the record or issue an industry notice that spells out the intent of the rule, and that the division no longer interprets "does not concur" as meaning only affirmative disagreement, and it means the attending physician does anything other than affirmatively agree in writing with the IME report. Thank you.

Fred Bruyns: Thank you Ted. Would you like us to enter that into the record as well. It's up to you entirely.

Ted Heus: It's just on outline.

Fred Bruyns: Okay. Is there anyone else present who'd like to testify this morning? Is there anyone on the telephone who'd like to testify?

Claire Hertz: Yes, this is Claire Hertz, chief financial officer with Beaverton School District.

Fred Bruyns: Oh, welcome Claire. I'll go ahead and enter you onto our testimony log. You may go ahead.

Claire Hertz: We have submitted a memo with feedback to the proposed rules, and when we look at it in the way that school districts operate in the state, there are some concerns about some of the language in the proposed rule. For instance, not all school districts submit a comprehensive annual financial report. Some of them do annual financial statements. So, we are concerned about, number one that having that language and that requirement is outside of the scope of the smaller school districts. The other is, when you look at the Moody's and S&P ratings that are included as part of the financial criteria – for instance, North Clackamas and Beaverton have both Standard and Poor's and Moody's, and we would qualify under one of the ratings and not qualify under the other rating, so we're not sure if it just has to be one of the two, and the other concern there is not all of the school districts have ratings because not all school districts issue bonds, so just making sure that its not a requirement to have those ratings.

The other is that we're – we would really like to propose language that takes into account the PERS unfunded actuarial liability as well as future OPEB, other post employment benefit liabilities, from GASB rules that require us to post long term liability for things that we pay as we go basis, and the, having that, we would like to exclude that in the calculation of the financial rating of school districts. So, just wanted to re-cover what we included in a memo that hopefully you already have at hand, and if not please contact me and I'd be happy to get that submitted properly if that's not already been done.

Fred Bruyns: Thank you very much, Claire, and this might be a good time to say that that testimony, along with Ted Heus' testimony, and then a little bit of testimony from the department in terms of some housekeeping changes, has been posted to our website, and there's a handout at the back of the room that shows you kind of how to get to that website. It's got the URL. So I would encourage you to go and look at the testimony, and additional testimony that's received after this hearing through the deadline of the 26th will also be posted to that website. All our testimony is now put online for all to see.

Is there anyone else on the telephone or here present who would like to testify? Hearing no one, I just want to remind you again that indeed the 26th is the deadline for written testimony, and that includes the 26th itself, the close of the business day, basically, or actually it could come in as late as 11:59 p.m., but you may submit testimony in any written form, whether hard copy or electronic. I encourage you to submit your testimony by email or as attachments to email. However, you may also use fax, USPS mail, courier, or you may hand deliver testimony to the Workers' Compensation Division Central Reception on the second floor of this building, the Labor & Industries Building. On the table by the entrance are business cards that include my contact information. I will acknowledge all testimony received.

It's our policy to leave hearings, at least the hearing room, open for a minimum of one-half hour, so I will remain here, and you are welcome to remain as well, or you may go. And this, a recording of this hearing and actually a typed transcript will be posted to our website as well, so you can find out if anybody arrives late. But otherwise, I'm going to recess the hearing. It is now 9:50, so this hearing is recessed.

This hearing is resumed at 10 a.m. Is there anyone here who'd like to testify, or on the telephone? Hearing no one, the time is still 10 a.m. This hearing is adjourned. Thank you for coming.

Transcribed from a digital audio recording by Fred Bruyns, Oct. 24, 2017.