Exhibit "1"

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: • OAR 436-009, Oregon Medical Fee and Payment • OAR 436-010, Medical Services • OAR 436-015, Managed Care Organizations • OAR 436-035, Disability Rating Standards	)	TRANSCRIPT OF TESTIMONY

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated February 2, 2025. On February 18, 2026, a public rulemaking hearing was held as announced at 11:30 a.m. via video and telephone conference. Marie Rogers, from the Workers' Compensation Division, was the hearing officer. The record will be held open for written comment through February 25, 2026.

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TRANSCRIPT OF PROCEEDINGS

Marie Rogers, Workers' Compensation Division (WCD):

Good afternoon and welcome. This is a public rulemaking hearing.

My name is Marie Rogers, and I'll be the presiding officer for the hearing today.

The time is now 11:30 a.m. on Wednesday, February 18, 2026. We are conducting this hearing virtually, by video and telephone conferencing. We are making a recording of the hearing.

The Workers' Compensation Division of the Department of Consumer and Business Services proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- OAR 436-009, Oregon Medical Fee and Payment
- OAR 436-010, Medical Services
- OAR 436-015, Managed Care Organizations
- OAR 436-035, Disability Rating Standards

The department has:

- Summarized the proposed rule changes and prepared an estimate of fiscal and economic impacts in the notice of proposed rulemaking filed with the Oregon Secretary of State;
- Published rulemaking notice 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 notice in its *Oregon Bulletin* dated February 2, 2026.

This hearing is not a meeting for back and forth discussion. Today's hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including February 25, 2026, and will make no decisions until all of the testimony is considered. Please note that, based on testimony received, the division may retain or revise current proposed rule language—or could decide to retract a rule change and revisit in a future rulemaking.

As with every rulemaking, the division will address all testimony received in a Testimony and Response document and publish that document on our website.

You may submit testimony in any written form. I encourage you to submit your testimony by email or as attachments to email. Those would come to me at marie.a.rogers@dcbs.oregon.gov. However, you may also use US mail. The email and physical address are on the Notice of Proposed Rulemaking. I will acknowledge all testimony received.

We are ready to receive public testimony.

Is there anyone who would like to testify at this time?

I see a hand from Ann Klein. Ann, would you like to take yourself off of mute and testify today?

Ann Klein, Majoris Health Systems:

Yes, thank you.

I would just like to reiterate some concerns that we highlighted previously regarding the proposal to change in the managed care organization chapter 436-015 to extend the time a worker can continue to treat outside network from 14 days to 30 days following enrollment.

We absolutely acknowledge and in fact have testified on the fact that Oregon does face provider shortages.

We also feel that the MCO is one of the strong tools within the system to support workers and navigating those challenges; our key concern in extending this time frame is that it won't materially impact or improve availability, but it will negatively lengthen the timelines and shift over the efforts of transitioning into network. And that, for us, is contrary to our goal of supporting smooth transition and good continuity of care, where really we think best practices as much as possible is to get that worker established in network as close to their original date of injury as possible.

So we do retain those concerns specific to delaying that transition and also delaying the ability, or inspiration, really, for the worker to reach out to the MCO and notify us that they may need help making that transition.

Marie Rogers, WCD

Thank you, Ann. I see a hand from Jovanna Patrick. Jovanna would you like to provide testimony?

Jovanna Patrick, Oregon Trial Lawyers Association (OTLA)

Yes, thank you for the record, Jovanna, Patrick, I represent workers and am part of OTLA.

I would just like to speak to Miss Klein's comments.

You know, I support the 30-day extension.

I think it's really important. MLAC went through a big process in the last year and what we found is it's really hard to transition and to find a new provider when a worker's put in an MCO. And so additional time is practical. I see this a lot. Workers have a hard time calling people.

And in my experience, it used to be you call an MCO doctor, they'd say, "Here's an appointment. Come on in." What I'm always getting now - almost across the board - is "I won't—" the doctor's office "won't see the worker until the adjuster sends me the entire claim file, we have the chance to review it and then we decide if we want to accept the worker or not." That process takes some time, understandably: for the documents to get sent, or the doctor to review them.

Oregon Occupational Medicine was out a month last time I checked—or just reviewing documents to decide. And so also the practical considerations. Mail is slower than it used to be. So workers, it takes them, you know, four to seven days to get the letter telling them they have 14 days. So, now we have less time.

And then I appreciate that the MCO was helpful in finding a doctor and that we can ask the MCO to help us find a doctor. And then they have 14 days to do it.

So if you add the mailing timeline, the time to request them so you'll find the doctor and the MCO's 14 days, we're well past the 14 days the worker has and now the worker's suffering. While no wage loss, no treatment. They can't get back to work. And that's a real problem.

I also really appreciate that the MCO can find us doctors and that we can ask them for it. But, you have to remember that one of the key tenets of workers' compensation is worker choice.

So if, because of this strict 14-day deadline, the truth is the only way a worker can get a doctor is to call the MCO and have the MCO suggest a doctor or schedule them, that really interferes with the worker's ability to choose, and to take time to look at the list, to research the doctors and maybe pick a doctor that they want and make the effort to get in there.

So, that's why additional time makes a lot of sense and it will help those workers and the MCO not having to scramble and let doctors have time to make a decision on whether they want to accept workers without the workers suffering a loss of benefits when their claim is accepted and they should be receiving benefits.

Thank you.

I appreciate your time.

Marie Rogers, WCD

Thank you, Jovanna.

Is there anyone else on the call today who would like to provide testimony?

I am seeing no hands.

I take it back. Jovanna would you like to provide additional testimony today?

Jovanna Patrick, OTLA

Yes, I'm looking for Keith Semple on this list and I'm not seeing him. And we were planning to discuss testimony on the preauthorization rule.

That's up right now, right? I'm not mistaking that?

Marie Rogers, WCD

Yes, yes, we would be taking testimony for the preauthorization rules today.

I don't see Keith either, and I don't have the lobby enabled. So it's not like he's waiting for admittance.

I am happy to put the hearing in recess and if Keith joins us later, he can provide testimony upon joining or if you'd like to provide testimony, Jovanna, you're welcome to do so.

Jovanna Patrick, OTLA

Yes, thank you.

I will go ahead and do that.
Just give me one moment because we were discussing it by e-mail and I had expected to follow up on his comments rather than make the initial ones myself.
So we are submitting a document—our comments. They've been submitted with OTLA's logo, I think.
Yeah, but I'd like to comment on some of those here.
So we're very concerned about this rule.
We don't feel like the rule encapsulates what the MCO, what the—excuse me—what MLAC had felt was needed, and what MLAC talked about all summer—last summer.

We appreciate that the rule is working on some changes and allowing preauthorization, but what we heard at the MCO meet—I'm sorry, I keep saying MCO—at the MLAC meetings over and over again was that from doctors that they cannot get insurers to respond to their requests for treatment.

We heard frankly terrifying testimony from Doctor Bowman, who's on MAC, who does surgeries and is well in the worker's comp system. He talked about how he basically has to trick the MCO or the insurer to approve post-surgical rehab in cases so that clients don't get adhesive capsulitis after a shoulder surgery.

We're talking about fully accepted claims and a doctor who knows everything about the system and he feels like he has to like trick his way into getting workers the treatment they need.

We heard from Doctor Takacs that insurers never respond and that they have like a full-time worker who knows how to do this and is constantly on them.

We heard from insurers and adjusters who get phone calls and faxes and emails, and it's just like, way too much information to try to respond in time. And sometimes they need something additional.

So the system doesn't really work. The whole idea with preauthorization—at least that I understood coming out of MLAC—was that we were going to try to make it a streamlined process where anyone, any provider in the system who wants preauthorization, can ask for it.

They can ask for it from an insurer, and there's some deadline and some mechanism to complain when it doesn't happen. We wanted it to—the suggestions we made as OTLA were that we allow it to be similar to the elective surgery rules where there's a request, it can be done by fax or e-mail. That way there's a clear indication of what is—what needs to be requested. And there's documentation that it's been done, and then there's a clear deadline to respond. And if there's not a response, it's taken just like surgery, elective surgery, that insurers can no longer challenge reasonableness of necessity.

And there's an appeal process. So right now, as written, the rule really looks like only certain providers can request it. There's only certain treatments that are allowed, and workers have the 60-day deadline from notice, even though we're often working with insurers who try to get what is needed to approve it, and that's problematic.

And so, we have suggested a rewrite of the rule. We feel like this is not ready to go to final rule. And that we ask that it be pulled back and more thought and discussion be given.

OTLA has proposed some changes in our letter—some significant changes—that would pull this in line with the surgical questions, with the way elective surgeries are done so that they're streamlining and frankly it will hold everyone accountable.

Because right now—what happens? I had worker who needed carpal tunnel release. Everyone agreed she needed it. She waited like five or six months, and now she's having a worse result.
And what the way it happened, I call the doctor. She says she's not getting surgery. I called the doctor. They say they don't have what they need. I call the insurer. They say they'll look at it. They say they never got the request. The provider sends me six or seven requests that they had fax cover sheet confirmation. Insurers attorney says they can't find it. We do this for like four or five months until we finally say yes, she needs surgery.

That is a broken system that is not the way it should work. And the rule, as written, doesn't fix that problem. Instead it puts a burden on the worker to somehow know when it was received and appeal, even though we oftentimes find out about these things way after the fact because we couldn't possibly know what the insurer doesn't have and they haven't sent us. So we feel like this rule is not ready to go to final rule. It needs a lot more discussion.

And I believe that Keith is getting on now to make some additional comments.

Thank you.

Marie Rogers, WCD

Thank you, Jovanna.

I will look for Keith's hand here.

I do want to also note that the proposed change does not limit the request to certain providers, but instead only limits the request to certain medical services. But the intent of the preauthorization rule is to create a standardized process for submitting requests for preauthorization. So we do appreciate that. And I look forward to seeing the letter. And as with the transcript for today's hearing, all testimony received—that will get published on our website and we will take all of that into consideration when deciding next steps for these rules.

Is there anyone on the call currently who would like to provide testimony today?

Jovanna Patrick. OTLA

And I don't mean to interrupt, but I just talked to Keith in text and he said he couldn't find the link. So I just emailed it to him. So I do believe he will be entering and would like to make some comments if that's permitted. Thank you.

Marie Rogers, WCD

Yeah, absolutely permissible.
I plan to leave the hearing open till noon today. I do see that Sydney Montanaro has her hand raised.

Sydney Montanaro, OTLA

issues with audio

I'm so sorry. I don't know what happened.
I didn't even change anything.
My name is Sydney Montanaro.
I'm a fellow member of OTLA and I'm just gonna add on to some of the testimony that Jovanna just gave.
I just wanted to reaffirm some of the concerns we have with this rule.
I wanted to highlight the lack—the specification that only certain treatment can be preauthorized.
Jovanna did touch on that, but I think it's important to highlight that further—that there are a number of types of procedures that are requested that just don't fall within this rule. That would be like nerve conduction studies, spinal cord stimulators, nerve stimulators, those are the kinds of procedures I often see requested where there's just a lot of back and forth with the insurer receiving the request, and then there's a lot of confusion on whether it's being approved or not.

So, the lack of inclusion of just any—limiting—having this rule limited to only certain services I think is a real problem and I just wanted to highlight that. I also wanted to highlight the 60-day deadline for a claimant which would be extremely challenging to track for an unrepresented worker, let alone for a worker represented by an attorney. It's not clear how someone would learn of that deadline, and that that's a real problem. This rule, as Jovanna pointed out, also doesn't solve that problem of just trying to understand when an insurer has actually received a request to authorize something, and so having some

kind of presumption is really important because this is an issue that's just coming up over and over and over again for workers, doctors and attorneys on both sides.

That's all. Thank you.

Marie Rogers, WCD

Thank you, Sydney and I do see Keith's hand. Keith Semple, would you like to provide testimony today? You are on mute, Keith. Let me see if I can unmute you.

OK, I see Keith has put in the chat that he will provide written comment. Which, I will reiterate: we are accepting written comments through the 25th of February next week.

And anything submitted to us as well as the transcript for today's hearing will be published on our website. OK. Let me see. Thank you everyone for the engagement today.

Is there anyone else on the call who would like to provide testimony today?

OK. I'm hearing no one and seeing no hands.

So, I will put the hearing in recess for the final 10 minutes here. I did want to leave it open until noon today in case we did have late arrivals.

Again, just reiterating the record remains open for written testimony through and including February 25th. And that would be for emailed and mailed testimony.

I'm gonna recess the hearing at 11:49.

OK, this hearing is resumed at 11:58.

I didn't see any hands or see anyone new arrive while we were in recess. But I'll call one last time for testimony today. OK, I am seeing no one, so I just want to reiterate anyone who would like to submit written comments for the proposed rules should submit them to me: Marie.a.Rogers@dcbs.org.gov. And anything received will be considered and posted on our website along with our response to that testimony.

So thank you all for coming.

I appreciate the engagement today. This hearing is adjourned.

Transcribed from a digital audio recording by Marie Rogers, February 18, 2026.