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June 12, 2026

Marie Rogers
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Via Email: marie.a.loiseau@dcbs.oregon.gov

RE: Written Comments
June 9, 2026 WCD Advisory Committee

Dear Ms. Rogers,

Thank you again for inviting me to attend the June 9, 2026, advisory meeting to discuss oversight and overreach of managed care organizations (MCOs). As anticipated, the comments were varied and highlight the disconnect between MCOs, providers, workers, and their representatives. It is that disconnect that the WCD has an opportunity to cure by clarifying the role of MCOs in the workers' compensation system. I offer the following written comments in furtherance of that goal.

As you know, I have written to the WCD regarding MCO behavior in the past. I would like to incorporate those comments into the record to ensure that the WCD keeps abreast of past and present MCO issues affecting the workers' compensation system.

The History and Background of MCOs

One significant deviation from past MCO presentations is that the MCOs, and often insurers, now take the position that that MCO involvement in non-medical benefits is not only allowed by the statute, ORS 656.260, but that the legislature always intended that result. That is historically inaccurate.

Creatures of Statute

As discussed, MCOs were created by the legislature in 1990. 1990 OR Laws Ch 2, Sec 12. This amendment was the result of the infamous Mahonia Hall Report. That report, prepared April 30, 1990, and issued by the Governor's Labor-Management Advisory Committee (now MLAC), identifies MCOs are a "[m]anaged medical *care* system [that] controls costs while delivering high quality and consistent standard of medical *care*, with unnecessary *care* eliminated." (Emphasis added).

The 1990 Special Committee on Workers' Compensation confirmed that the then-proposed law, SB 1197, confirmed that *insurers* should stay out of the MCO's purpose, "which is managed quality *care* for the workers." Testimony of Cecil Tibbits, Interim Special Committee on Workers' Compensation (May 3, 1990) (emphasis added). Mr. Tibbits added that the amendments allow the director to "set standards" for an MCO to prevent insurer influence from occurring.

When asked about the scope of medical services provided by MCO medical providers, the proponents responded that "medical services" was adequately defined in ORS 656.245. Testimony of Ross Dwnnel, United Grocers.

The 1990 MLAC Package Agreement explained that the amendments "make[] substantial changes in the way medical *care* will be delivered." MLAC Package Agreement at 3 (April 1990) (Emphasis added). It explained that MCOs were to "provide methods of peer review and service utilization review to prevent inappropriate or excessive *treatment." Id*. at 4.

The OLA Staff Measure Summary explained, under the heading "Medical Care," that the amendments "[a]llows insurers or self-insured employers to contract with medical care organizations (MCO) to *provide medical services*." Preliminary Staff Measure Summary, Oregon Legislative Assembly (May 2, 1990) (emphasis added).

This is but a sampling of the legislative history regarding the creation of MCOs. The only discussion about allowing MCOs to affect non-medical benefits is the brief discussion about how insurers would be kept separate from MCOs, specifically discussing SAIF and Liberty Mutual's inability to form their own MCOs or maintain PPOs, so that such interference and collusion could not occur.

In direct contrast to the history, MCOs and insurers, including SAIF, at the June 2026 meeting insisted that the legislature *wanted* insurer-MCO collusion to affect non-medical benefits. That is revisionist and the legislative history does not support that position. The legislature did not even want collusion involving *medical* related benefits.

Oversight

The legislative history is also rife with references to the director being responsible for overseeing the conduct of MCOs. Witnesses' various concerns with the amendments were dismissed with the caveat that if the concern came to fruition, the director would promulgate rules to quell the concern. Director oversight of MCOs was a cornerstone of the amendments, assuming that, if MCOs overstepped their role, the director would provide guardrails. Regrettably, the director has failed to provide that oversight.

Ms. Whelchel's comments highlight this failure. She rightfully asked about data showing the frequency and results of complaints. I know that complaints are few and far between, and results almost non-existent. But this lack of data is not evidence that the problem does not exist; it is evidence that the current complaint system, to the extent there is one, is failing.

Over the past several years, I have tried many ways of approaching MCO misconduct, as have many of my colleagues. My colleagues and I have occasionally obtained orders assessing penalties against *insurers* for MCO misconduct, but neither I nor my colleagues have ever successfully held an MCO accountable for its own conduct. As I stated in my comments, since MCOs were created by statute 36 years ago, I have not seen a single order assessing a monetary penalty for misconduct

under ORS 656.745. That is not a result of the system working, that is a result of system that does not provide adequate oversight of MCO conduct.

Continuing Examples

For years, the director has been made aware of various complaints about MCO misconduct, general and specific. In December 2023, I wrote the WCD and provided examples of misconduct. In December 2025, I provided continuing examples of misconduct and inference with non-medical benefits. I have since filed numerous complaints with the director, requested administrative review, and requested hearings alleging MCO conduct. The director hears comments from lawyers, workers, and medical providers about MCO misconduct. In addition to these past examples, I offer the following new ones:

- In June 2023, an insurer filed a complaint against an attending physician with an MCO because the attending physician asserted in chart notes that the worker should receive vocational benefits if they are unable to return to regular work. The MCO held a "peer call" with the attending physician, reported to the insurer that "it was not a great call" and that the MCO was not sure what else it could do to help the insurer. The MCO's role is not to help the insurer avoid liability for vocational services.

- In September 2025, an MCO contacted a worker's attending physician whether specific impairment findings were due the injury. It also asked about the worker's ability to *permanently* perform certain types of work. The MCO did not ask about or pretend to have any interest in medical care or treatment. The information was sought for the purposes of closing the claim and determining permanent impairment.

- In October 2025, an MCO conducted a "medical treatment review." The stated goals were "the worker does not seem to have been released to the appropriate level of work" and "treating for denied conditions." The MCO review achieved its goal by "advancing work restrictions" by separating accepted condition from denied conditions. The "medical treatment review" only reviewed work restrictions, not medical treatment.

- In November 2025, an MCO contacted a "come along" provider, informing them that MCO acts as the liaison between the physicians treating on a claim and the insurance company in order to gather "information the *insurance company* needs in order to continue processing the claim." The MCO stated the purpose of the discussion would be the workers' "work release." The result of that discussion was the agreement that the worker was medically stationary for the "accepted conditions" but still needed treatment and had work restrictions for the "denied conditions." The discussion did not have anything to do with medical treatment for the worker or a care plan. It was to help the insurer deny or reduce worker benefits, such as temporary disability or permanent disability.

- In February 2026, a worker's attending physician felt the worker was not medically stationary and needed work restrictions. An MCO contacted the attending physician

demanding a referral to a different office for the sole purpose of *changing attending physicians*. The MCO then contacted the insurer and asked *the insurer* if it would like the MCO to contact the attending physician again regarding the work restrictions. The MCO's demand had nothing to do with medical care or medical treatment, but "case management."

- In March 2026, an insurer contacted an MCO demanding an MCO find a provider for a worker who had asked to be released from the MCO for failing to provide an adequate number of physicians. The insurer demanded the MCO find a provider because the insurer "need[ed] to remain in as much control over this one as I can, it is already off the rails." The insurer is asking the MCO to help the insurer "remain in control" of a claim by directing care the certain physicians.

- In April 2026, an insurer contacted an MCO about an attending physician who had not "complied" with an agreed plan to release the worker to modified work and had instead continued to release the worker to a full work release. The insurer noted that the attending physician seemed to be focused on the fact the employer had terminated the worker and asked the MCO to intervene. The MCO activated a "medical treatment review" to review the attending physician's "noncompliance regarding the agreed plan." The MCO's review was conducted at insurer's request to reduce or limit temporary disability compensation, as insurer and MCO knew there was no modified work to return to.

- Also in April 2026, an MCO contacted a physician to inquire about "objective findings" that indicate ongoing pathology of a specific diagnosis. The MCO explain the legal definition of "medical stationary," and asked if that, using that definition the specific diagnosis was medical stationary. The *legal definition* of medically stationary, and especially as it pertains to a specific accepted condition, is not relevant to treatment or a medical care plan. It is used to determine entitlement to temporary disability and close the claim for that specific condition.

- In May 2026, an insurer contacted an MCO with help obtaining the attending surgeon's response to insurer's request for a work release, because "the employer said [worker] has been doing the modified job since before this work injury." The MCO sent the physician a copy of provider manual, explaining that the physician could not request pre-payment, and then offered to send a letter to the physician threatening "escalating" the matter the "Provider Relations Department" if the physician did not respond within 48 hours to the insurer's request. This inquiry had nothing to do with care and was an effort to obtain closing information from the surgeon to limit permanent disability.

These examples show that MCO interference through collusion with insurance companies continues to be a concern among workers and providers. The director should also note that all of these examples, gleaned from many sources, are very recent. This means it is likely that such behavior occurs all the time, in many claims, that are not brought to the attention of the director.

Conclusion

MCOs continue to act as shadow insurers. They continue to process claims in the dark. They continue to do so with no meaningful oversight. The administrative rules need to change to be sure that MCOs are performing the duties the legislature intended them to perform, not the duties delegated to insurers.

I look forward to the Fall rulemaking and will do my best to present different potential rule-making solutions to the WCD at that time.

Sincerely,

Theodore P. Heus
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Enc: 12/8/23 Letter to WCD (Mr. Heus); 9/29/25 Letter to WCD (Mr. Heus)

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December 8, 2023

Marie Loiseau
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RE: Comments on Managed Care Organization
Review of Division 010 and Division 015

Dear Ms. Loiseau,

Thank you again for inviting me to attend the November 30, 2023 rulemaking advisory meeting and inviting me to present on my colleagues and I see as a growing problem in the workers' compensation system.

As you know, I am an Oregon attorney who has practiced Oregon workers' compensation law for nearly 20 years. My career is nearly evenly divided between representing employers and insurers and representing Oregon workers. I consider myself an expert in the field and have a thorough understanding of how the system works to serve stakeholders.

Over the last few years, I have noticed that managed-care organizations (MCOs) are becoming directly involved in workers' receipt of non-medical benefits, such as temporary disability, permanent disability, and vocational services. I believe this has a negative and unfair impact on Oregon's workers and their ability to obtain benefits under the law.

The Purpose of MCOs

The November 30, 2023 meeting was very useful. It was a relief to hear that the stakeholders agree that MCOs were created to ensure the effective use of medical services and, as made clear in 1995, were charged with "service utilization review."[1] This is consistent with the administrative rules defining "Managed Care Organization," Medical services, and "Medical treatment." See OAR 436-010-0005(23), (26), (28).

[1] Notably, I have heard the term "medical management" used to describe the MCOs authority and duties. I have heard this term used by agents of the MCO and by WCD employees. But the term "medical management" does not appear in the statutes nor in the director's rules. In contrast, terms such as "medical treatment," "medical services," and "service utilization review" are used and defined by law governing MCOs.

Unfortunately, it also became very clear that MCOs and insurers view medical services to encompass *anything* a doctor does or is required to do under the workers' compensation law or an MCO contract. This validates my concern that MCOs consider interference in non-medical benefits appropriate and within their statutory authority because they have recharacterized medical services to include all benefits under the statute.

I strongly disagree with that characterization and so should the director. The summaries given to the Management and Labor Advisory Committee (MLAC) during its April 14, 2022 meeting describe MCOs' involved only in medical treatment. Neither the narrative summary nor the slide presentation described MCO involvement in other benefits, such as temporary or permanent disability, vocational eligibility, claim processing, or compensability litigation. They further described themselves as "neutral" in terms of claim processing.

In my experience, MCOs have lost any badge of neutrality. I have several cases in which the MCOs are directed by the insurer to communicate with the attending physician concerning non-medical benefits with the expectation that the communication will benefit the insurer.

At the November 30, 2023 meeting, was able to give only a short summary of the examples I and my colleagues' clients have experienced. I will remedy that here.

MCO Intrusion and Overreach

As I commented, I have noticed MCOs expanding their involvement beyond medical treatment into other benefits, sometimes subtly, sometimes brazenly. This is despite no law allowing such intrusion. *See* ORS 656.260(4) (describing the scope of managed care plans as providing "medical and health care services" as required by law); ORS 656.262(1) (providing that claim processing be limited to insurers); ORS 656.780(3) (providing that only certified claims examiners may process claims).

Temporary Disability

Temporary disability is often the most important benefit to workers, allowing them to continue to survive financially while treating and recovering from a work-related injury. Yet, this is the most common benefit MCOs interfere with.

As a recent example, an MCO sent a letter to a worker's attending physician, informing them of the contractual requirements under the MCO-provider agreement. The letter warned the provider that he is subject to two requirements: 1) a minimum of one office visit every 30 days is required but *only for workers who have physical restrictions*, and 2) the provider may authorize temporary disability for *no more than thirty days at a time*. There are no exceptions for medical decision making. *See* Majoris Provider Manual (location and page unknown).

Pursuant to the contractual requirements, even if the worker is unable to work because of ongoing or permanent medical conditions, such as awaiting surgery, recovery from surgery, loss of a limb, or paralysis, the provider is contractually limited to authorize only 30 days of temporary disability at a time.

Despite the comments to the contrary, creating contractual obligations addressing temporary disability authorizations is not related to medical services. It contravenes the statute prohibiting a provider from advocating for temporary disability and it contravenes the definition of medical

treatment under the administrative rules; and it contravenes the definition of "service utilization review." ORS 656.260(4)(d)(B), (4)(i); OAR 436-010-0005(28).

My clients have also experienced MCOs demanding their attending physicians provide more specific work restrictions. The specificity of work restrictions may be relevant to the insurer or employer when offering modified work, but they are irrelevant to the MCO's service utilization review. They are also irrelevant to providing medical services.

My clients have experienced insurers demanding that MCOs discipline attending physicians for "not addressing work restrictions in the chart note" and "providing the worker with open-ended temporary disability authorizations." Neither of these demands, based on presumed contractual obligations, have anything to do with service utilization review, medical services, or medical treatment.

My clients have experienced MCOs directing attending physicians to release a worker to modified work at the next visit, using mandatory language. Again, releasing a worker to modified work has no apparent relationship to medical services or medical treatment.

Intrusion into Permanent Disability

Another recent example is an MCO's attempt to influence a client's permanent disability award via a "disability prevention consultation," and under the guise of a "program involving cooperative efforts by the workers, the employer and the managed care organizations to promote workplace health and safety consultative and other services and early return to work." ORS 656.260(4)(e).

This statute was mentioned during the November 30, 2023 meeting as potential legal foothold to expand the influence of MCOs into reviewing individual work restrictions and temporary disability. However, the statute does not apply to individual cases, only to programs involving the MCOs, employers, and workers. Notably, such programs do not include insurers. Similarly, they are "cooperative" programs, not secret programs, and not designed to influence an individual worker's benefits in a specific case.

Through this process, MCOs have attempted to dictate and limit a provider's imposition of work restrictions and closing examinations for injured workers. This is not consistent with MCOs' prior testimony given to MLAC. While MCOs admit that this practice occurs "at the request of an insurance adjuster when an injured worker is not improving or advancing in their return to work," they allege that goal is to reach "alternative treatment options if appropriate." (4/14/22 MLAC Meeting, Jennifer Lawlor, M.D.). The testimony to MLAC omitted the intended effect on permanent disability benefits by limiting access to physical capacity evaluations or selection of providers to provide closing examinations.

My clients have also experienced MCOs communicating with the attending physician to produce a concurrence report that determined that worker has no work restrictions or permanent impairment "due to the accepted conditions." This represents an MCO attempting to interfere with both permanent impairment findings and compensability. Neither of these benefits are related to service utilization review, medical services, or medical treatment.

Intrusion into Vocational Services

A colleague's client experienced an MCO communicating with an attending physician after the provider recommended vocational retraining. The insurer demanded the provider be disciplined for "asserting in chart notes that an injurer worker should receive vocational rehabilitation if the are not able to return to regular work capacities." According to the MCO, the call was "not a great call," presumably because the attending physician continued to support vocational rehabilitation benefits.

Intrusion into Claim Processing and Litigation

MCO overreach also takes the form of claim processing. I am aware of more than one case where an insurer asked an MCO to help obtain a provider's concurrence with an independent medical evaluation regarding compensability or closure of the claim. In one case, because compensability litigation was anticipated, the insurer wanted the MCO's help to avoid additional exposure for new conditions.

And I am aware of a case in which the MCO sent a concurrence letter directly to a provider after a conversation with that provider to discuss the worker's "work release" and to obtain agreement that the "accepted conditions" did not require ongoing work restrictions. This is consistent with another case where an MCO decision letter disapproved medical treatment for the sole reason that it was not appropriate for the "accepted condition." It did not address whether the requested treatment was appropriate for the worker's injury or the worker themselves. Causation is not within the purview of MCOs and is not service utilization review, medical services, or medical treatment.

At the November 30, 2023, an insurer representative commented that she would contact the MCO to compel a physician to respond to claim processing questions, because, although the rules required a response, they did not provide a dead to respond. This is an admission that the MCO are used by insurers as work arounds to remedy what they see as deficiencies in the administrative rules governing claim processing, not medical services.

Solutions

I am cognizant that this is a large issue that has not fully come into the light. However, it continues to grow as the number of MCOs dwindle. The more claim processing MCOs do, the more insurers will rely on that processing. The director has oversight of MCOs and has statutory authority to dictate and enforce limitations on MCO contracts and activity. But the director must choose to do so.

Process

The natural result of MCOs treating non-medical benefits as medical benefits is that the director must now accept administrative review of non-medical issues. For instance, when a worker disagrees with the extent or duration of work restrictions, the MCO must first review them pursuant to medical treatment guidelines and the director must review that determination. I believe this is a sharp departure of the scope of issues the director is accustomed to reviewing in medical disputes.

Transparency

The front and center solution is transparency. Although there may be legitimate policy reasons to keep *some* aspects of MCO contracts confidential, such as provider fees and schedule fees, those aspects do not override the rights of injured workers. Workers have an absolute right to know what processes insurers and providers use when making determinations about benefits. There is no policy served by subjecting workers to hidden agreements and provisions that bind them and their medical providers.

The director has authority to disclose MCO contracts as it deems appropriate and necessary. The director should create a rule and process that allows a worker who becomes subject to an MCO contract or whose provider is subject to an MCO contract to have the right to review all provisions of those agreements. This would allow workers to understand what their physicians are obligated to do and shed light on why some decisions about their care and benefits are being made.

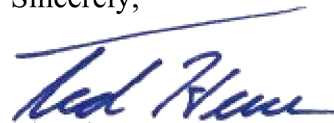
Conclusion

MCOs are acting as shadow insurers. They are processing claims in the dark. They are holding providers to contractual provisions that directly affect the extent and duration of non-medical workers' compensation benefits. They are doing so with no meaningful oversight, no ability for workers to view the provisions that bind them, and no ascertainable avenue for workers to challenge some MCO actions. The administrative rules need to change to be sure that MCOs are performing the duties the legislature intended them to perform, not the duties of insurers.

I respectfully ask the director to consider the above problems, the offered solutions, and make rules to help cure some these problems that currently afflict Oregon's most vulnerable workers: those that have sustained accepted disabling injuries.

If the director has questions, I am happy to provide more examples of documentation of those examples provided. If the director would like to form a more focused advisory committee on this problem, I am happy to participate to the extent practicable.

Sincerely,



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September 29, 2025

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RE: Recommended Agenda Item
Chapter 436, Division 015

Dear Ms. Loiseau,

Thank you again for inviting me to attend the November 18, 2025, rulemaking advisory meeting and to offer agenda items. I have attached a completed "Rule Issue Form" to this letter.

I am an Oregon attorney who has practiced Oregon workers' compensation law for nearly 20 years. My career is nearly evenly divided between representing employers and insurers and representing Oregon workers. I consider myself an expert in the field and have a thorough understanding of how the system works to serve stakeholders.

As noted in my December 8, 2023, letter, MCOs continue to interfere with workers' benefits, acting on behalf of the insurer or at the insurers request to communicate with the worker's treating providers. Thus, I would like the committee to continue discussions on MCO involvement in *non-medical* benefits, such as temporary disability, claim closure, permanent disability, and vocational services. MCO involvement in these non-medical benefits is not authorized by statute. MCO involvement beyond determining appropriate medical services for a worker exceeds the statutory authority of an MCO.

Continuing Examples

In December 2023, I provided examples of MCOs interfering with injured workers' non-medical benefits. That behavior continues unabated.

As a recent example, a third-party administrator provided a workers' private medical information to an employer representative who then personally directed the MCO to contact the attending physician and solicit information to close a claim, including concurrence with a closing examination. There was no request to review appropriate medical treatment. Rather, the MCO was used to obtain closing information for the employer and employer's claim processor solely to

reduce the worker's permanent disability award. This behavior represents an abuse of the limited authority given to MCOs to determine appropriate medical treatment.

My colleagues' clients have experienced similar MCO behavior. In one case, an MCO verbally instructed an attending physician that she was authorized to only provide four physical therapy treatments and then must release the worker to regular duty work and declare her medically stationary. This was the attending physician's first visit on a claim that has been denied and then accepted after litigation.

Recommendation

Because this behavior continues to be a problem for workers and their medical providers, I recommend the director adopt a rule clarifying the scope of MCO authority by prohibiting certain MCO conduct. I propose adopting a new rule:

OAR 436-015-XXXX: Prohibited Conduct

(1) An MCO or someone acting on behalf of an MCO may communicate with medical treatment providers only regarding the provision of medical services. An MCO may not communicate with medical providers regarding non benefits, including, but not limited to:
(a) Medically stationary status under ORS 656.005(17) and ORS 656.268(1);
(b) Sufficient information to close a claim under ORS 656.268 or Division 030 under these rules;
(c) Restrictions on the workers' ability to perform or return to regular or modified work;
(d) The necessity or duration of temporary disability authorization;
(e) Closing examinations or information used to rate permanent impairment partial disability under ORS 656.214 and Division 035 of these rules;
(f) Permanent total disability under ORS 656.206; or
(g) Information used to determine eligibility for vocational services under ORS 656.340 or Division 120 of these rules.

(2) Violation of this section will result in a civil penalty assessed in accordance with ORS 656.745(2)(a) and OAR 436-015-0120. Each prohibited communication shall be considered a separate violation for the purpose of assessing a civil penalty.

Conclusion

MCOs continue to act as shadow insurers. They continue to process claims in the dark. They continue to do so with no meaningful oversight. The administrative rules need to change to be sure that MCOs are performing the duties the legislature intended them to perform, not the duties delegated to insurers.

If the director has questions, I am happy to provide more examples of documentation of those examples provided. If the director would like to form a more focused advisory committee on this problem, I am happy to participate to the extent practicable.

Sincerely,

Theodore P. Heus
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Enc: Possible Rule Issue Form

Possible Rule Issue Form

Complete this form, save, and submit by:
Email: wcd.policy@dcbs.oregon.gov, Fax 503-947-7514, or
Mail to Attn: Policy Team, Workers' Compensation Division, P.O. Box 14480, Salem, OR 97309-0405

A policy analyst will contact you.

Date of request: **Name and contact information:**

If this issue is related to an existing rule within Oregon Administrative Rule, chapter 436, which rule is it?

Brief summary of issue:

What data illustrates the issue? (Example: How often does it occur?)

What stakeholders are impacted by this issue and how are they impacted?

What is a potential solution and how does it solve or improve the issue?

To your knowledge, has this issue been raised or discussed before?