

The Success of Medical Provider Networks in the California Workers' Compensation System

Historical Context and a Review of Current Data/Research

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Executive Summary

The California Medical Provider Network (MPN) framework is a well-functioning infrastructure that expedites access to care with shorter durations of disability for injured workers, lowers claim costs for employers, and reduces the proportion of disputes relative to non-networked claims. The MPN system has been in place since 2004, created in response to a Worker's Compensation system that was historically in crisis, with runaway medical costs, poor outcomes, and rampant fraud in the system. This white paper (1) evaluates the impact of the statewide physician shortage, (2) examines the historical context of the MPNs, (3) discusses the interplay between MPNs and Preferred Provider Organizations (PPOs), (4) summarizes a recent independent study showing the effectiveness of networks in facilitating access to care for injured workers, and (5) reviews the dispute resolution statistics and alternatives that currently exist for contracted providers.

Our central findings are:

1. **The Worker's Compensation physician (and specialist) access problem in California is real — but its root cause is an overall statewide physician shortage that persists across all healthcare delivery systems.** California *barely met half* of its primary care physician needs in 2024 and nearly 11.4 million Californians — one in four — live in a federally designated physician shortage area. California's physicians-in-training per capita rate trails nationwide averages, and our statewide provider shortage problem is exacerbated by an aging physician workforce and a relatively large percentage of part-time physicians.
2. **Medical Provider Networks were originally created in 2004 as part of SB899 to curtail spiraling medical costs and escalating employer premiums.** Subsequent studies have demonstrated the effectiveness of the MPN model at remedying those issues. The managed care (MPN) model was later expanded as part of the SB863 reforms.
3. **PPO's and MPN's are not synonymous.** Understanding the interplay between the two different constructs is imperative to drive informed public policy considerations.
4. **Network use produces measurably better outcomes for injured workers nationwide.** A new March 2026 WCRI¹ study of 152,472 matched claims across 34 states found that in-network claims had faster initial care access, shorter disability durations, lower total claim costs and lower litigation expenses compared to out-of-network claims. These savings were consistent every year from 2018 through 2023. These positive impacts were particularly pronounced among comparatively lower-fee-schedule states, including California.
5. **Contract-related friction is minimal, and adequate remedies exist for provider contract-related disputes.** The Independent Bill Review process, which may be utilized by providers for reimbursement disputes with a contractual component, is accessed very rarely, reflecting overall satisfaction with network contracts. Similarly, provider requests for copies of contracts from networks are also rare. Several dispute resolution alternatives already exist for providers, including in-contract ADR processes, and the WCAB, in addition to IBR.

¹ *Impact of Networks on Claim Outcomes*, by Olesya Fomenko, Rebecca (Rui) Yang, Workers' Compensation Research Institute (WCRI), March 31, 2026 at <https://www.wcrinet.org/reports/impact-of-networks-on-claim-outcomes>

I. The California Physician Shortage: A “Plague” on ALL Healthcare Delivery Systems

Injured workers sometimes face difficulty accessing care (particularly specialists, and particularly in rural areas) within the Worker’s Compensation system, but this difficulty is indicative of a much broader problem: **California is experiencing a severe, statewide physician shortage affecting every healthcare delivery system and every patient population.**

The data from authoritative sources is stark:

- **One in four Californians lives in a shortage area:** Approximately 11.4 million Californians—nearly one quarter of the state’s entire population—live in a federally designated Primary Care Health Professional Shortage Area². The physician shortage does not impact all areas of the state equally: patients in rural, semi-rural, and inland regions are much more likely to be adversely affected, as some rural communities have ratios closer to one physician per 1,100 residents, compared to the one primary care physician for every 160 residents ratio seen in more urban locations³. The map below from “Let’s Get Healthy California” highlights areas of the state that fail to meet the 2000:1 Population to Provider ratio considered to be acceptable from an access perspective for primary care physicians. All areas shaded light green and light teal fall below that threshold:

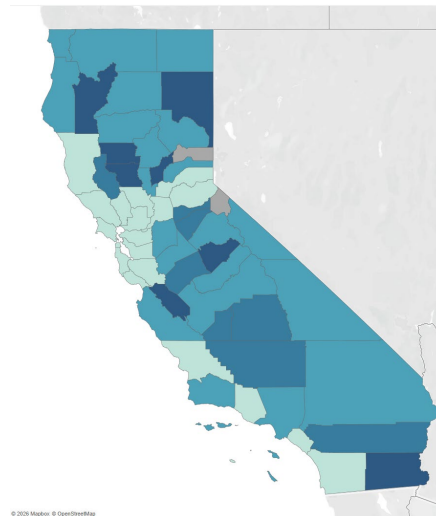


Figure 1-Primary Care Shortage Areas

Source: Let’s Get Healthy California at <https://letsgethealthy.ca.gov/goals/redesigning-the-health-system/increasing-access-to-healthcare-providers/>

- **California meets only 54% of its primary care needs:** In 2024, California met just 54% of its primary care needs⁴. That same year, it would have required 881 additional physicians to

² California Assembly Budget Subcommittee No. 1 on Health — February 23, 2026 Hearing Agenda (PDF) at <https://abgt.assembly.ca.gov/system/files/2026-02/sub-1-agenda-feb-23-hearing.pdf>

³ *Ibid.*

⁴ *California Needs More Than Medical Schools to Solve Doctor Shortage*, by Sally C. Pipes, Pacific Research Institute for The Mercury News, 11-6-2024 at <https://www.pacificresearch.org/california-needs-more-than-medical-schools-to-solve-doctor-shortage/>

eliminate all the state's designated primary care shortage areas⁵, and this shortfall has likely increased in the two years since.

- **California is facing a projected shortfall of 10,500 providers by 2030:** The National Center for Health Workforce Analysis projected that California faced a shortage of 3,490 primary care physicians in 2025 alone, with earlier expert estimates projecting a need for approximately 10,500 additional primary care providers by 2030 to meet demand⁶.
- **An aging physician workforce is accelerating the crisis:** In 2023, 25% of active California physicians were age 65 or older⁷. In a March 2026 survey of specialists in rural Northern California, 55% said they plan to retire within five years, citing burnout, financial pressures, and lack of support. Shasta County's health officer even declared the situation a "public health crisis."⁸
- **California trains far fewer physicians per capita than the national average:** California has only 23 medical students per 100,000 population, compared to 41 nationally, and 37 residents and fellows per 100,000, compared to 48 nationally⁹. The training pipeline is structurally insufficient to keep pace with population needs.
- **Specialist shortages are projected nationally across WC-relevant specialties:** The National Center for Health Workforce Analysis projects that by 2038, orthopedic surgery will be at only 88% adequacy, physical medicine and rehabilitation at 85%, family medicine at 76%, and vascular surgery at 66%.¹⁰ Concerningly, these are the very specialties most relevant to workers' compensation care.
- **Only 40% of California physicians work full-time:** In 2023, only 40% of California's licensed physicians provided patient care for 40 or more hours per week, further constraining effective supply¹¹. Furthermore, less than one-third practiced in private practice¹².

Impacts on the Workers' Compensation System

California's workers' compensation system is experiencing physician shortages in parallel with those seen in other healthcare delivery systems throughout the state. Not surprisingly, many California medical institutions—such as UCLA, UCSF, Stanford, and Cedars-Sinai—have chosen not to treat workers' compensation patients to manage capacity in the context of the larger physician shortage. Their decisions reflect the economics of an undersupplied physician market and

⁵ *Ibid.*

⁶ *Ibid* from Assembly Budget Subcommittee Report. See also "Get Health California" at <https://letsgethealthy.ca.gov/goals/redesigning-the-health-system/increasing-access-to-healthcare-providers/>

⁷ *Ibid.*

⁸ *Survey Highlights Worsening Shortage of Physicians in Rural Northern California*, by Heather Stringer and Shaun Walker, California Health Care Foundation (March 21, 2026) at <https://www.chcf.org/resource/new-survey-highlights-worsening-shortage-physicians-rural-northern-california/>

⁹ *Ibid* from Assembly Budget Subcommittee Report, citing the Healthforce Center at UCSF, 2025 Report at <https://healthforce.ucsf.edu/project/shortage-primary-care-workers-california>

¹⁰ *Physician Specialty Projections Factsheet*, HRSA / National Center for Health Workforce Analysis — (December 2025) at <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf>

¹¹ *California Physicians Almanac 2025 Edition*, California Health Care Foundation (March 2026) at <https://www.chcf.org/resource/california-physicians-almanac/>

¹² *Ibid.*

underscore the importance of the MPN's role within Workers' Compensation in facilitating access to available care.

Data from the March 2026 WCRI report demonstrates that **within the existing physician supply, in-network claims improve access to care**: In-network injured workers see physicians nearly three days sooner and access physical medicine services 13 days sooner than out-of-network claimants¹³. These statistics underscore the importance and effectiveness of the Medical Provider Network framework in the Workers' Compensation system. The WCRI report will be reviewed in detail later in Section 4 of this paper.

Policy Efforts to Address the Shortage

In response to the larger statewide crisis, **many California agencies and the legislature are evaluating potential policy alternatives**. As cited in the Assembly Budget Subcommittee report, physician workforce development—via more medical school capacity, more residency slots in underserved regions, and better loan repayment incentives - are all tools that California's legislature and governor are actively pursuing¹⁴.

In a potential bright spot, as noted in the 2026 Assembly Budget Report, **"California has been awarded \$233.6 million in 2026 through the federal Rural Health Transformation Program to support rural and frontier communities. The program... will include a workforce development component, with a focus on strengthening training pathways and clinical placement networks, as well as recruitment and retention"**. More information on the California State Office of Rural Health is available [here](#).

¹³ *Ibid* from *Impact of Networks on Claim Outcomes* by WCRI.

¹⁴ *Ibid* from Assembly Budget Subcommittee Report.

II. The Medical Provider Network (MPN) System: Reform Built by Necessity

SB 899 (2004)

California Senate Bill 899, enacted in 2004, was a sweeping legislative reform that fundamentally overhauled the state's workers' compensation system. It established the current MPN structure, adopted evidence-based medical treatment guidelines, strengthened utilization review, and capped the number of therapy visits. The reforms were a direct response to systemic failures seen throughout the system:

1. Despite a dramatic overall downward trajectory in the incidence rate of occupational injuries and illnesses from 1990 to 2004, costs in the state's WC system were rising dramatically¹⁵. According to a 2006 "Fact Sheet" report from CHSWC, "...employers' WC premiums in California skyrocketed from \$5.8 million in 1995 to \$20.2 billion in 2003—a 348 percent rise. Medical costs were responsible for much of [that] increase, with the ultimate medical cost per indemnity claim rising from \$9,041 in 1993 to \$25,560 in 2002..."¹⁶
2. Utilization of physical medicine treatments (particularly chiropractic services and physical therapy) were surging without corresponding improvements in worker outcomes.
3. Long-duration treatment claims were rising while return-to-work outcomes remained poor.
4. Without network structure, injured workers were exposed to providers with no occupational medicine training or accountability—and to fraud schemes that treated patients as commodities.

A RAND Corporation study found that the 2004 reforms produced meaningful results¹⁷: permanently disabled workers in California returned to work in greater numbers. Among the medical care improvements resulting from the creation of MPNs was the guarantee that treating physicians would be licensed and qualified, coupled with a systematic review of physician performance and reduced reliance on liens.

RAND also identified specific structural advantages that MPNs delivered over open arrangements¹⁸: MPNs concentrate care with physicians who have occupational health experience; they create established referral and communication patterns between primary treating physicians and specialists; they allow selective contracting with efficient providers; and they enable provider education on MTUS guidelines. These are not incidental features of the MPN model. They are the model's design intent.

¹⁵ *Fact Sheet: Workers' Compensation Medical Care in California: System Overview (2006 UPDATE)*, CHSWC, October 2006, pgs. 1-2 at <https://www.chcf.org/wp-content/uploads/2017/12/PDF-WorkersCompOverview06.pdf>, citing the California Division of Labor Statistics and Research.

¹⁶ *Ibid.*

¹⁷ *Medical Care Provided Under California's Workers' Compensation Program: Effects of the Reforms and Additional Opportunities to Improve the Quality and Efficiency of Care*, by Barbara O. Wynn, Justin W. Timbie, Melony E. Sorbero, Published 8/22/2011, <https://www.rand.org/pubs/monographs/MG1144.html#citation>

¹⁸ *Ibid.*

SB 863 (2012): Labor and Management Improved What Was Working

In 2012, following extensive collaborative labor-management negotiations, [SB 863](#) introduced further refinements to the MPN structure. Rather than replacing MPNs, these reforms strengthened them:

1. A new Medical Access Assistant role within the MPN framework was created, providing injured workers with active guidance in locating appropriate in-network care rather than leaving them to navigate provider lists alone.
2. New roster and network access standards took effect January 1, 2014, establishing enforceable standards for timely treatment, sufficient provider availability by specialty, and network transparency.
3. MPN application approvals were issued on a 4-year review cycle, with the MPN applicant submitting geocode data and defined Quality Assurance (QA) processes. The DWC Medical Unit was expanded to assess compliance with these standards¹⁹.
4. The law mandated care provision within the MPN when one is in place, closing the gap between network enrollment and actual network use.

Post-implementation cost evaluations by the Workers' Compensation Insurance Rating Bureau (WCIRB) noted that these reforms were effective in reducing medical spend in the Workers' Compensation system, with refinements to the MPN infrastructure alone culminating in aggregate savings of \$190 million²⁰. Coupled with other medical cost spend provisions, the savings had "...largely driven a series of advisory pure premium rate decreases totaling more than 40% [that] resulted in in the lowest average charged premium rates in the marketplace in more than forty years"²¹. The following chart was excerpted from WCIRB's post-863-implementation report:

Medical & LAE Cost Components		
Changes to Lien Filings	-\$480	-2.5%
Spinal Implant Hardware Reimbursements	-\$110	-0.6%
Changes to Ambulatory Surgical Center Fees	-\$80	-0.4%
IMR Impact on Frictional Costs	\$70	0.4%
IBR Impact on Frictional Costs	\$0	0.0%
Medical Provider Network Strengthening	-\$190	-1.0%
RBRVS Changes to Physician Fee Schedule	-\$330	-1.7%
Indirect Impact on Overall Medical Utilization	-\$1,770	-9.3%

Figure 2-Systemwide Savings from MPN's

Details on the MPN application process, including state-mandated forms, and a list of active MPN's is available from the [DWC Medical Unit](#).

¹⁹ CA Dept of Industrial Relations, Div. of Workers Comp, Medical Unit at <https://www.dir.ca.gov/dwc/MedicalUnit/imchp.html>

²⁰ *SB 863 Cost Monitoring Update*, by the WCIRB Actuarial Services Team, WCIRB, October 2019, at https://www.wcirb.com/sites/default/files/documents/research_brief_october_2019_sb_863_cost_monitoring_update.pdf

²¹ *Ibid.*

III. The Interplay Between Medical Provider Networks (MPNs) and Preferred Provider Organizations (PPOs)

PPOs and MPNs are not synonymous. In the California Workers' Compensation system, many MPN applicants retain the services of network contracting entities to assist them in building out their MPN infrastructure (including meeting state-mandated access requirements). Network contracting entities work directly with individual providers, medical groups, medical facilities, *etc.* to build ready-made PPO networks of providers throughout the state. Providers contracting with these entities often agree to accept reduced reimbursement rates in exchange for having patient traffic directed to their practices. A single MPN may be comprised of multiple PPOs affiliated with it (*e.g.*, one PPO focused on physician services, a second focused on facilities, and a third focused on ancillary services; alternatively, sometimes different PPOs focus on different geographical areas). Conversely, a PPO's network list of providers may be tapped into by multiple MPNs.

Characteristics and Benefits of Shared (or "Leased") Networks

The use of shared or "leased" PPO networks to meet access standards is neither new, nor is it restricted only to Workers' Compensation: the practice is common in the commercial health and dental plan markets, just to name a few. In Workers' Compensation, use of "leased" networks encourages competition among MPN's, as it allows smaller MPN market entrants (who lack the size, capital, and negotiating power to build out a network infrastructure on their own) to compete with larger entities. Furthermore, use of leased networks makes the contracting process easier for providers: currently, there are approximately 300 active MPNs in the system, but many of those MPNs use common PPOs. As a result, if a provider signs a contract with one PPO, they may be able to reap the benefits (and patient referrals) of being included in multiple employer MPNs (and directories), without having to negotiate separately with each MPN.

MPNs and PPOs Are Distinct Constructs

Provider participation in both PPOs and MPNs is voluntary, although each is created through a separate mechanism. **Preferred Provider Organizations (PPOs)** are collections of private contractual arrangements between providers (individual or group) and various contracting entities. They are created and governed by commercial contract law. Providers may sign PPO agreements that include multiple payment delivery systems (such as Commercial Health, Workers' Comp, and/or PIP Auto services all at a common rate) or just encompass Workers' Compensation. Providers generally may terminate contractual network PPO agreements unilaterally, often with relatively short written notice to the network²².

Medical Provider Networks (MPNs) are constructs of the [California Labor Code](#)²³ and [DIR administrative rules](#).²⁴ An MPN allows an employer to provide an injured worker with a

²² Term notice periods vary by contract, with ranges typically spanning from 30 to 120 days.

²³ Labor Code Sections §§ 4616 through 4616.7, at https://www.dir.ca.gov/t8/9767_1.html

²⁴ California Code of Regulations, Chapter 4.5. Division of Workers' Compensation, Subchapter 1. Administrative Director--Administrative Rules, Article 3.5. Medical Provider Networks, Section 9767.1 *et seq.* at https://www.dir.ca.gov/t8/ch4_5sb1a3_5.html

directory/list of available physicians, facilities and ancillary providers, from which the injured worker may select a provider(s). MPNs carry specific access requirements, filing obligations with DWC, geographic coverage standards, and are subject to periodic audits by the DWC. In short, MPNs are heavily regulated by the state. The DWC requires participating physicians in MPNs to sign a Physician Acknowledgement, verifying in writing that the physician wants to participate in an MPN. [Cal. Code of Regulations §9767.5.1](#) outlines the administrative rules for Physician Acknowledgments with MPNs.

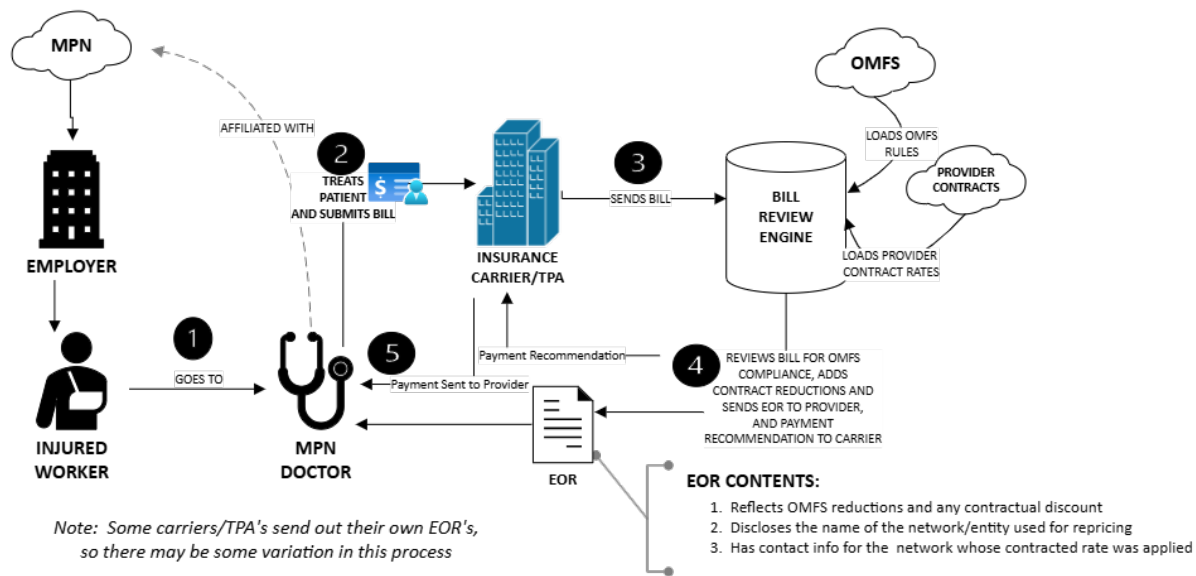


Figure 3-MPN/PPO Interplay in CA WC

Having a baseline understanding of the differences between these two constructs and how they work together is critical in considering public policy changes. PPO-related data (including provider contracting information and rates) is housed in one area/data store and is often maintained by staff that work solely with providers (negotiating contracts, updating provider contact information, etc.) PPO data is often tapped as a source to populate provider directories, access provider contracted rates, etc. By contrast, MPN-related data is often housed in a completely different location, and is maintained by staff that are well-versed in the specific rules governing MPNs outlined above: access standards, physician acknowledgments, etc.

If a provider's reimbursement for a particular service has been reduced in conjunction with a contract for a Workers' Compensation patient, Labor Code Section 4609 is triggered.²⁵ Section 4609 includes safeguards for providers with respect to the use of PPO contracts, detailing rules for contract rate transparency, etc. In other words, LC §46909 addresses the point at which PPOs and MPNs intersect.

²⁵ [Labor Code Section 4609](#) sets out transparency and related requirements associated with network leasing arrangements.

IV. An Overview of Current Data: Networks in California Are Working

WCRI Research: In-Network Claims Deliver Better Outcomes

A March 2026 study by the Workers' Compensation Research Institute (WCRI)²⁶, provides the most current and methodologically rigorous evidence on network performance in workers' compensation. The study analyzed 152,472 matched claims from 34 states—representing approximately 86% of all workers' compensation benefits paid nationally—using a statistical “matching” approach that controls for injury type, worker demographics, industry, and geographic area to isolate the effects of network participation alone. California is explicitly included among the study states.

The WCRI findings are consistent, statistically significant at the 1% level, and unambiguous in their conclusions:

1. **Faster Access to Care:** In-network claimants received their first office visit nearly three days sooner (20% faster) than non-networked claimants. Physical medicine services were accessed 13 days sooner (23% faster), and diagnostic radiology services were accessed more quickly as well.²⁷
2. **Shorter Disability and Faster Return to Work:** Temporary disability duration was 1.5 weeks shorter for in-network claimants (15.8 weeks vs. 17.4 weeks). In-network claims were also 26% less likely to result in permanent partial disability or lump-sum settlement payments.²⁸
3. **Better-Quality Care:** In-network providers directed care toward *conservative treatment*: in-network claimants were 15% more likely to receive physical medicine and 13% more likely to receive diagnostic radiology, but 16% *less* likely to undergo major surgery and 17% *less* likely to receive pain management injections. This care pattern is associated with the lower costs observed.²⁹
4. **Lower Total Claim Costs:** In-network claims had 26% lower total costs on average (\$33,793 vs. \$45,612). Every major cost component showed savings: medical payments were 28% lower (\$11,862 vs. \$16,514), indemnity benefits 23% lower (\$16,883 vs. \$21,976), and benefit delivery expenses 29% lower (\$4,953 vs. \$7,002).³⁰
5. **Fewer Disputes and Lower Litigation Costs:** In-network claims experienced 12% fewer litigation filings and 39% lower litigation expenses per claim (\$4,055 vs. \$6,663).³¹

²⁶ *Impact of Networks on Claim Outcomes*, by Olesya Fomenko, Rebecca (Rui) Yang, Workers' Compensation Research Institute (WCRI), March 31, 2026 at <https://www.wcrinet.org/reports/impact-of-networks-on-claim-outcomes>

²⁷ *Ibid* at Page 2 — *Executive Summary*, Page 3 — *Table ES.1: Time to 1st E&M visit*, Page 15 — Chapter 3 opening narrative on access to care, Page 16 — *Table 3.1 (Effect of Networks on Medical Payments and Utilization)*, and Page 17 — *Table 3.2 (Effect of Networks on Time to First Medical Treatment, by Service Type)*.

²⁸ *Ibid* at Page 2 — *Executive Summary*, Page 4 — *Table ES.2: Duration of temporary disability*, Page 22 — *Table 3.6*, and Page 23 — Chapter 3 narrative.

²⁹ *Ibid* at Page 3 — *Table ES.1: Physical medicine*, Page 16 — *Table 3.1*, and Pages 17–18 — Chapter 3 narrative discussion.

³⁰ *Ibid* at page 2, *Executive Summary*, Page 4 — *Table ES.2 (Effect of Networks on Total Costs per Claim and Key Components)*, Page 22 — *Table 3.6 (Effect of Networks on Total Costs per Claim and Key Components)*. See also Pages 22–23 — Chapter 3 for a narrative analysis of these charts.

³¹ *Ibid* at Page 2 — *Executive Summary*, Page 22 — *Table 3.6*, and Page 23 — Chapter 3 narrative.

6. **Consistent Savings Over Time:** Network savings in medical payments per claim were documented in every year from 2018 through the first quarter of 2023, ranging from 18% to 27%. The savings are not a recent anomaly; they reflect a durable structural effect.³²

Specific Implications for California

The WCRI report contains information detailing the network participation rates by state. From the bar chart in Figure 1.2, California falls in the upper portion of the distribution across the 34 states — above 70% network participation, consistent with most study states. The range across all states was 43% (Louisiana, Minnesota) to 90% (New Jersey)³³.

California is also explicitly identified in the report in a footnote to Table 3.8 as one of the ten "**Lower Fee Schedule**" states (alongside Delaware, Florida, Louisiana, Maryland, Massachusetts, Michigan, New York, Oklahoma, and South Carolina)³⁴. California's MPN regulatory framework also places it in four additional subgroups: States with **time frame requirements**³⁵, states with **specialty coverage requirements**³⁶, states with **utilization review requirements**³⁷, and states with **treatment guidelines requirements**³⁸ — meaning California falls in the "Yes" row for all four of the managed care regulation tables (Tables 3.10–3.13 in the report).

California's **lower fee schedule environment** is where networks deliver their **greatest access gains** — 27–28% faster time to first visit, and 30% more physical medicine utilization and reduced reliance on surgery. California's **full managed care regulatory framework** (qualifying for all four subgroups) is associated with a **larger relative network impact across every measure**, including better treatment guideline compliance. California's **MPN/employer-control structure** generates 23% lower medical payments and 22% faster access to major radiology services compared to out-of-network care. All of this means California is not a state where networks are underperforming — it is a state where the evidence predicts networks should perform at or above the multistate

³² *Ibid* at Page 20 — Chapter 3 narrative lead-in to Table 3.5 and Page 21 — Table 3.5 (*Effect of Networks on Medical Payments per Claim over Time, 2018–2023Q1*) and Figure 3.1.

³³ *Ibid* at page 8.

³⁴ *Ibid* at page 27.

³⁵ The report defines inclusion in this category as "Whether or not a state's managed care regulations have a requirement on the time frame within which the worker must be seen after request for treatment", *Ibid* at pg. 29. California's timeframe requirements are outlined in 8 CCR §9767.5(f), stating that an MPN must ensure that an appointment for the first treatment visit is available within 3 business days of notice that treatment is needed. For specialists, the MPN must provide access within 20 business days 8 CCR §9767.5(g). See https://dir.ca.gov/t8/9767_5.html

³⁶ The report defines inclusion in this category as "Whether or not a state's managed care regulations have a requirement on specialties that must be included", *Ibid* at pg. 29. California's requirements related to specialties are included in Labor Code § 4616(a)(1) for statutory authority, 8 CCR § 9767.5(a) and (a)(2) — for regulatory authority governing the specific specialty and geographic minimums, and 8 CCR § 9767.1 — for regulatory authority governing the directory expansion enforcement mechanism. See <https://codes.findlaw.com/ca/labor-code/lab-sect-4616/> and https://dir.ca.gov/t8/9767_5.html.

³⁷ The report defines inclusion in this category as "Whether or not a state's managed care regulations have a requirement for utilization review", *Ibid* at pg. 29. California's Utilization Review requirements are mandated in Labor Code § 4610 and detailed in regulations set forth in 8 CCR §§ 9792.6–9792.10. See <https://codes.findlaw.com/ca/labor-code/lab-sect-4610/> and <https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I832A00A05A0F11EC8227000D3A7C4BC3&bhcp=1&bhash=1&transitionType=Default&contextData=%28sc.Default%29#I3628C2D1EB9911F09143F94D53AA9CD7>

³⁸ The report defines inclusion in this category as "Whether or not a state's managed care regulations have a requirement for treatment guidelines", *Ibid* at pg. 29. The mandate for treatment guidelines in the CA Workers' Compensation system is housed in Labor Code § 5307.27 (Statutory Mandate to Adopt Guidelines), Labor Code § 4604.5(a) (Presumptive Correctness — the Enforcement Mechanism), and in regulations at 8 CCR § 9792.21(c) (Regulatory Confirmation). See https://california.public.law/codes/labor_code_section_5307_27, <https://codes.findlaw.com/ca/labor-code/lab-sect-4604-5/> and <https://www.law.cornell.edu/regulations/california/8-CCR-9792.21>

average, precisely *because* California has the regulatory infrastructure that makes networks most effective.

The following table summarizes all 4 main subgroup conclusions from the WCRI report:

California MPN Managed Care Regulation Profile — WCRI Network Study Subgroup Data			
<small>Source: WCRI "Impact of Networks on Claim Outcomes," Fomenko & Yang, March 2026 (Tables 3.10-3.13, pp. 31-34). California falls in the "Yes" subgroup for all four categories. * = statistically significant at 1% level.</small>			
Time Frame Requirements Table 3.10 (p. 31) — California: YES			
<small>Regulation: 8 CCR §9767.5(f) — first visit within 3 business days; §9767.5(g) — specialist within 20 business days</small>			
Measure	In-Network	Out-of-Network	Relative Difference
Medical payments per claim	\$6,867	\$8,907	-23%*
Time to 1st office visit (days)	9.6	13.4	-28%*
E&M visits per claim	8.5	7.2	+19%*
% with physical medicine	76.4%	58.1%	+31%*
% with major surgery	18.0%	20.7%	-13%*
% with major radiology	46.9%	37.3%	+26%*
Specialty Coverage Requirements Table 3.11 (p. 32) — California: YES			
<small>Regulation: Labor Code §4616(a)(1) and 8 CCR §9767.5(a) — minimum 3 physicians per specialty within geographic access standards</small>			
Measure	In-Network	Out-of-Network	Relative Difference
Medical payments per claim	\$7,767	\$10,916	-29%*
Time to 1st office visit (days)	10.3	13.3	-23%*
% with physical medicine	75.3%	62.1%	+21%*
% with major surgery	19.1%	23.4%	-18%*
% with major radiology	50.9%	43.6%	+17%*
Utilization Review Requirements Table 3.12 (p. 33) — California: YES			
<small>Regulation: Labor Code §4610 — all employers mandated to maintain UR program; 8 CCR §§9792.6-9792.15</small>			
Measure	In-Network	Out-of-Network	Relative Difference
Medical payments per claim	\$7,843	\$10,929	-28%*
Time to 1st office visit (days)	10.2	13.1	-21%*
% with physical medicine	75.5%	62.6%	+21%*
% with major surgery	19.7%	24.1%	-18%*
% with major radiology	51.2%	44.3%	+16%*
Early MRI (within 6 weeks)	20.9%	20.2%	Not significant
Treatment Guidelines Requirements Table 3.13 (p. 34) — California: YES			
<small>Regulation: Labor Code §5307.27(a) (MTUS mandate); §4604.5(a) (MTUS presumptively correct); 8 CCR §9792.21(c)</small>			
Measure	In-Network	Out-of-Network	Relative Difference
Medical payments per claim	\$7,113	\$10,114	-30%*
Time to 1st office visit (days)	10.0	13.0	-23%*
% with physical medicine	74.8%	62.2%	+20%*
% with major surgery	19.0%	23.5%	-19%*
% with major radiology	49.8%	43.8%	+14%*
Early MRI (within 6 weeks)	19.8%	20.3%	Not significant
<small>Notes: Claims with >7 days lost time; injuries Jan 2022-Mar 2023; 12-month experience; pooled 34-state data. California 'Yes' placement; Time Frame — 8 CCR §9767.5(f)(g); Specialty — Lab. Code §4616(a)(1) & 8 CCR §9767.5(a); Util. Review — Lab. Code §4610; Treatment Guidelines — Lab. Code §§5307.27, 4604.5(a) & 8 CCR §9792.21(c).</small>			

Figure 4-Summary of Findings from 2026 WCRI Report

V. Contract-Driven Dispute Rates and Dispute Resolution Alternatives

Contract-Related Friction is Minimal³⁹

The following sections provide detail on the tiny fraction of IBR requests processed by the DWC that relate to contract issues, as well as comparably small number of contract disclosure requests received from providers.

Contract-Related IBR Issues are Infinitesimally Small

In 2024, approximately 11 million workers' compensation medical bills were processed through the California Workers' Compensation system. According to the DWC, of the total annual bill volume, only 3,958 bills were challenged through the Independent Bill Review process, meaning **99.96% of bills moved through the system without triggering formal disputes**. Of the 3,958 IBR filings, **only 136 involved contract-related issues**. As such, **IBR filings citing contractually related issues accounted for only 0.001236% of total California bill volume:**

Metric	2024	Jan–Aug 2025	Significance
Total CA bills processed	~11,000,000	N/A	Baseline
Total IBR filings	3,958	3,209	0.04% of bills
Contract-related IBR filings	136	139	3.44–4.33% of IBRs
Contract issues as % of CA bill volume	0.001236%	Est. comparable	Infinitesimal

Figure 5-Contract-Related IBR Filings

Data Source: Presentation by George Parisotto, DWC Director, at AWCP Conference, Sacramento, October 24, 2025.

³⁹ As noted by WCRI *supra*, the presence of a network on a claim reduces the likelihood that the overall claim will be litigated. This section focuses on a related issue - the number of disputes related to *medical bills specifically* - rather than overall litigation rates.

Contract Disclosure Requests Are Rare

Furthermore, we examined the number of requests for copies of contracts coming from providers on our Provider Assistance hotlines, to assess if these requests are commonplace. The data is clear – providers rarely request copies of contracts, and the volume of requests in California mirrors that seen in other states. The chart below outlines the data our members provided. **Requests for copies of contracts comprise approximately 2% of the volume of provider inquiries that our members receive.**

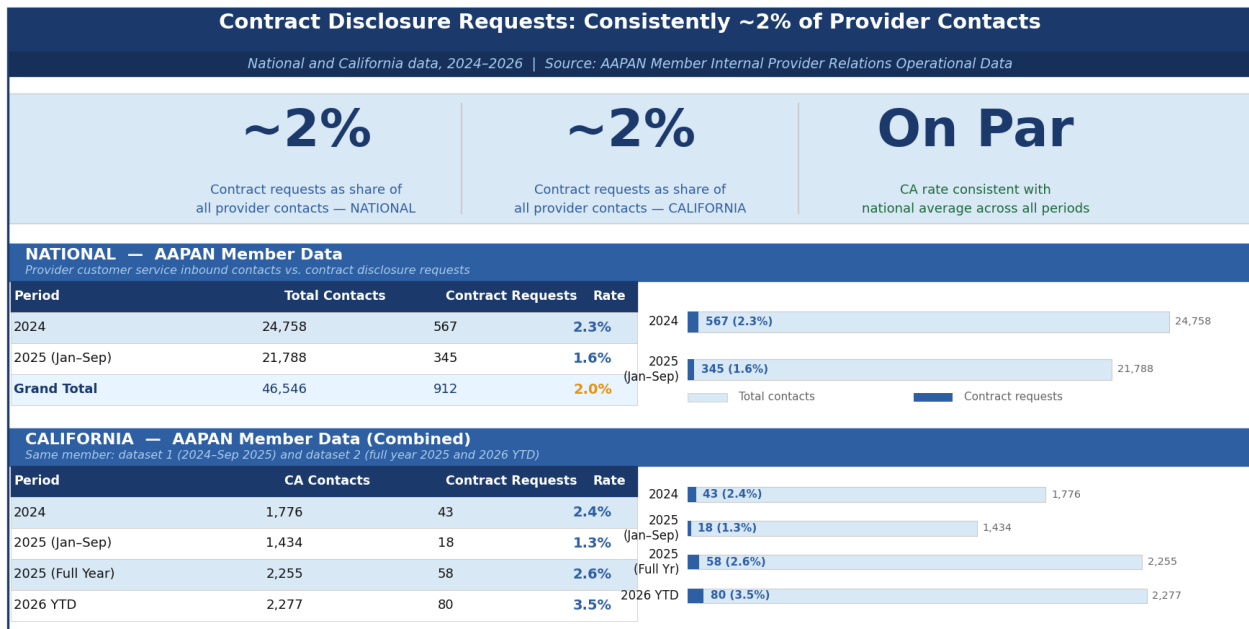


Figure 6-Contract Disclosure Requests

Adequate Provider Remedies Exist for Resolution of Contract-Related Disputes

As discussed above, contract-related disputes are very rare, accounting for small fraction of the total bill volume in the state. Nonetheless, should a provider desire to take further action on a reimbursement dispute, there are several existing alternatives for providers to pursue.

ADR/Contract Remedies

Many provider contracts have provisions that outline and/or mandate the use of Alternative Dispute Resolution (ADR) processes for resolution of contractual disputes. *Invocation of these provisions is comparatively rare.* The following excerpt provides an example of ADR language contained in a standard provider contract:

9.0 DISPUTE RESOLUTION

9.1 Dispute Resolution and Mediation.

Company will provide an internal procedure under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal procedures before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

9.2 Arbitration.

To the maximum extent permitted by applicable law, the Parties mutually agree to resolve any and all disputes between or among them exclusively through final and binding arbitration before the American Arbitration Association ("AAA"), rather than in court or before any administrative or regulatory body. This agreement to arbitrate ("Arbitration Provision") is governed by the Federal Arbitration Act, and it will apply to all claims, including but not limited to, those arising out of or relating to this Agreement (including the termination of this Agreement). The Parties waive their right to have any dispute or claim brought between them heard or arbitrated as a class action or collective action. Any dispute will be arbitrated on an individual basis only. Any claim that all or part of this Class Action Waiver is unenforceable, unconscionable, void, or voidable may be determined only by a court of competent jurisdiction and not by an arbitrator. Except with respect to the enforceability, revocability, or validity of the Class Action Waiver, only an arbitrator, and not any Federal, State, or local court or agency, shall have the exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this Arbitration Provision. The arbitrator

Figure 7-Sample ADR Contract Language

Independent Bill Review

Adopted as part of SB863 discussed *supra*, if a provider is unable to resolve a contractual dispute using a contract's built in ADR processes, the provider may make use of the Independent Bill Review (IBR) process, outlined in [Labor Code Section 4603.6](#) with regulations outlined in [8 CCR § 9792.5.7](#). **As discussed above, this process is very rarely invoked by providers for resolution of contract-related issues.** If there is a question as to *whether* a contract applies to a disputed bill, that issue must first be resolved, either by (a) agreement of the parties that a contract exists and is applicable, or (b) by determination of an ALJ. Once that threshold issue is resolved, assuming the provider has properly complied with the Second Bill Review process outlined in [§9792.5.5](#), an IBR request may be filed, including, "if applicable, [the] relevant contract provisions for reimbursement rates under Labor Code 5307.11"⁴⁰ The initial filing by the provider triggers an evaluation process by the IBR reviewer to validate that the request is appropriate for IBR, and that all necessary documentation has been included along with the request. The following diagram outlines the IBR process:

⁴⁰ CCR 8 CCR §9792.5.7(d) at https://www.dir.ca.gov/t8/9792_5_7.html

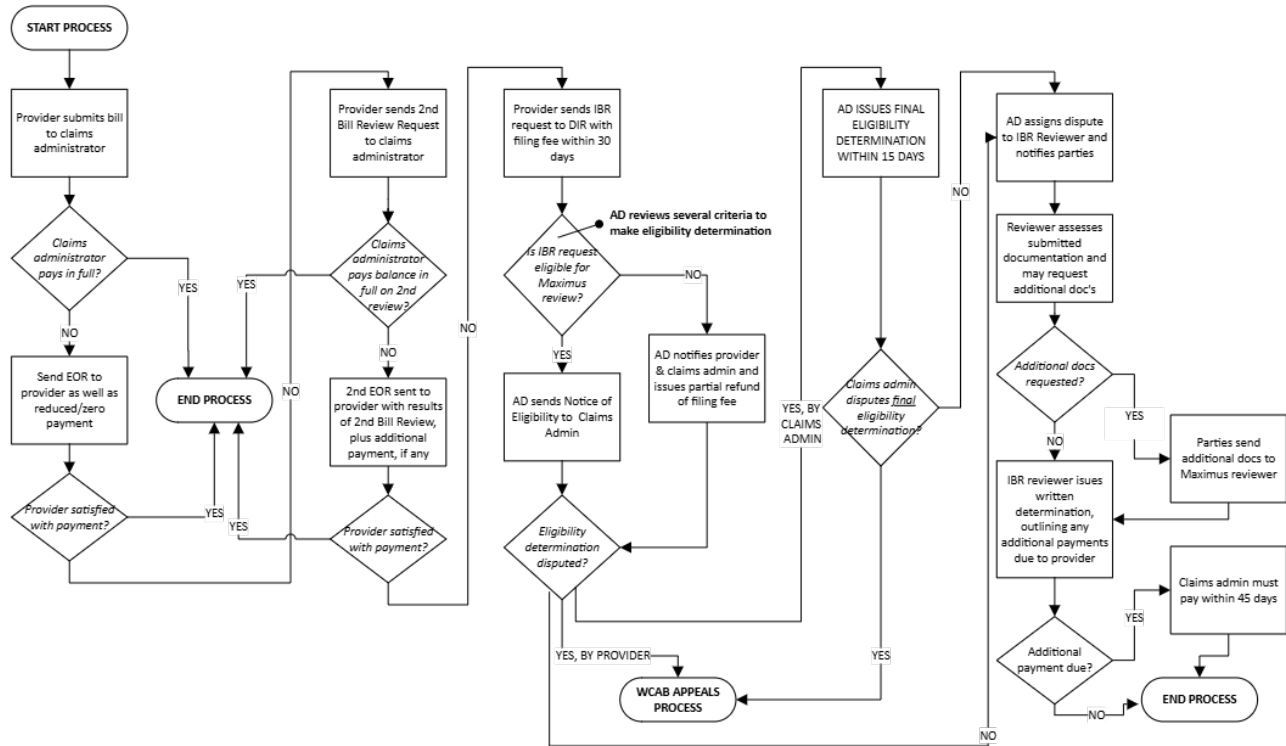


Figure 8- The IBR Process

Administrative Remedies

In addition to the ADR and IBR processes outlined above, there are several other longstanding remedies available to providers associated with resolution of medical bills, and penalties for inappropriate payment of bills.

Medical Treatment Bills

Under [California Labor Code Section 4603.2](#), employers and claims administrators must follow specific timelines for paying medical treatment bills.

- **Timeframe:** Employers have 45 days from the receipt of a complete, itemized medical billing to pay or object to the bill. The deadline is 60 days for state and local government employers.
- **Late payment penalties:** If payment is not made on time, the employer must pay the bill plus two automatic penalties:
 - A 15% increase on the amount due.
 - Interest calculated at 10% per year, retroactive to the date the bill was received.

Medical-Legal Bills

Under [California Labor Code section 4622](#), employers have different timeframes and penalties for medical-legal bills, which cover costs for proving or disproving a contested claim.

- **Timeframe:** The bill must be paid within 60 days of the claims administrator receiving the complete medical-legal report and itemized billing.

- **Late payment penalties:** If payment is unreasonably delayed, the penalty is:
 - A 10% increase on the unpaid portion of the bill.
 - Interest calculated at 7% per year, retroactive to the date the bill was received.
- **Objecting to the bill:** The claims administrator can avoid the penalty if they object to the bill's reasonableness or necessity within the 60-day window.

Sanctions for Bad-Faith Actions ([Labor Code § 5813](#))

This provision applies to any party in a workers' compensation case, including lien claimants, attorneys, insurance carriers, and employers.

- **Penalty:** A workers' compensation judge or the WCAB can order a party to pay the opposing party's reasonable expenses, including attorneys' fees and costs, for "bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay".
- **Additional sanctions:** The WCAB may also impose additional sanctions of up to \$2,500, which are sent to the state's General Fund.
- **Applicability:** This penalty can be applied to actions taken by any party during the adjudicatory process, such as a claims administrator unreasonably denying payment or a lien claimant filing a frivolous lien.

Unreasonable Delay of Benefits ([Labor Code § 5814](#))

This provision penalizes unreasonable delays or denial of any workers' compensation benefit, which can include payments to medical providers.

- **Penalty:** If an employer or carrier is found to have unreasonably delayed or denied a payment, the payment is increased by up to 25%, with a maximum of \$10,000.
- **Distinction from other penalties:** While Labor Code sections 4603.2 and 4622 apply specifically to billing payment, Labor Code section 5814 can be applied more broadly to an entire class of benefits if there is a pattern of unreasonable delays.

Potential "Add-On" Penalties:

The late payment penalties under sections 4603.2 and 4622 are "self-executing," which may give rise to audits and related penalties if defendants fail to pay them in a timely manner, absent a negotiation to waive them.

Dispute Resolution: Synopsis

There are many existing remedies available to providers to resolve contract-related matters, but the data is clear: *contract-related friction in the system remains small as an overall percentage of bill volume in the California Workers' Compensation system.* Educational outreach opportunities are encouraged to inform providers of the varied remedies available to them.