

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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AAPAN

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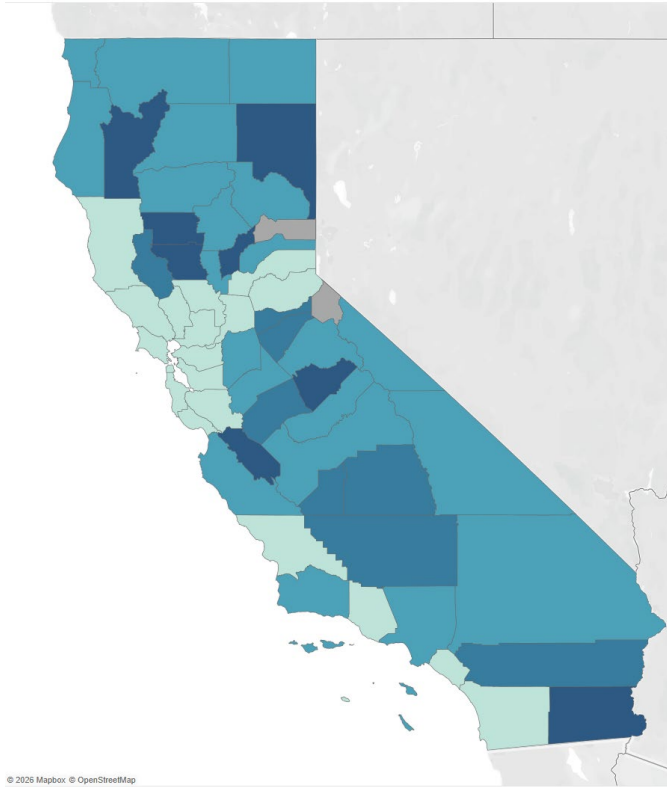
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Executive Summary/Key Points

- California is facing a **state-wide** provider shortage
- The MPN model was enacted to address real and measurable issues within the Workers' Compensation system
- MPNs and PPOs are not synonymous
- **In-network claims outperform OON claims and provide more timely access to care, shorter disability durations, lower claim costs and lower litigation costs**
- Contract-related friction is minimal, and adequate remedies exist for provider contract-related disputes



California's Medical Provider Crisis



Primary Care Shortage Areas in CA

- California meets only 54% of its primary care needs
- California is facing a projected shortfall of 10,500 providers by 2030
- An aging physician workforce is accelerating the crisis and only 40% of California physicians work full-time
- California trains far fewer physicians per capita than the national average
- Specialist shortages are projected nationally across WC-relevant specialties
- Policy efforts have been undertaken to address the shortage
- Feds have provided \$233.6 million to help expand rural access to care

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



History Lessons: Why the MPNs Were Created

The WC System Before SB899

- Dramatic escalation of costs despite downward trajectory in claims incidence
- Overutilization of physical medicine (chiropractic; PT)
- 348% increase in premiums from 1995 to 2003
- Medical costs increased from \$9,041 in 1993 to \$25,560 in 2002
- Long-duration treatment claims increased; RTW rates were poor
- No managed care: unvetted providers

**Source:* 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.

*The WC System After SB899**

- Permanently disabled workers in California returned to work in greater numbers
- MPNs were created:
 - Providers were vetted with license and experience checks
 - Allowed for selective contracting with efficient providers



History Lessons: Why the MPNs Were Created (Cont'd)

Further Reforms in SB863 (2013)

- Medical Access Assistants were added
- New roster and access standards were added
- 4-Year review cycle for MPN's established, with geocode requirements and defined QA processes
- Medical costs increased from \$9,041 in 1993 to \$25,560 in 2002
- Eliminated “sidestepping” the MPNs using liens

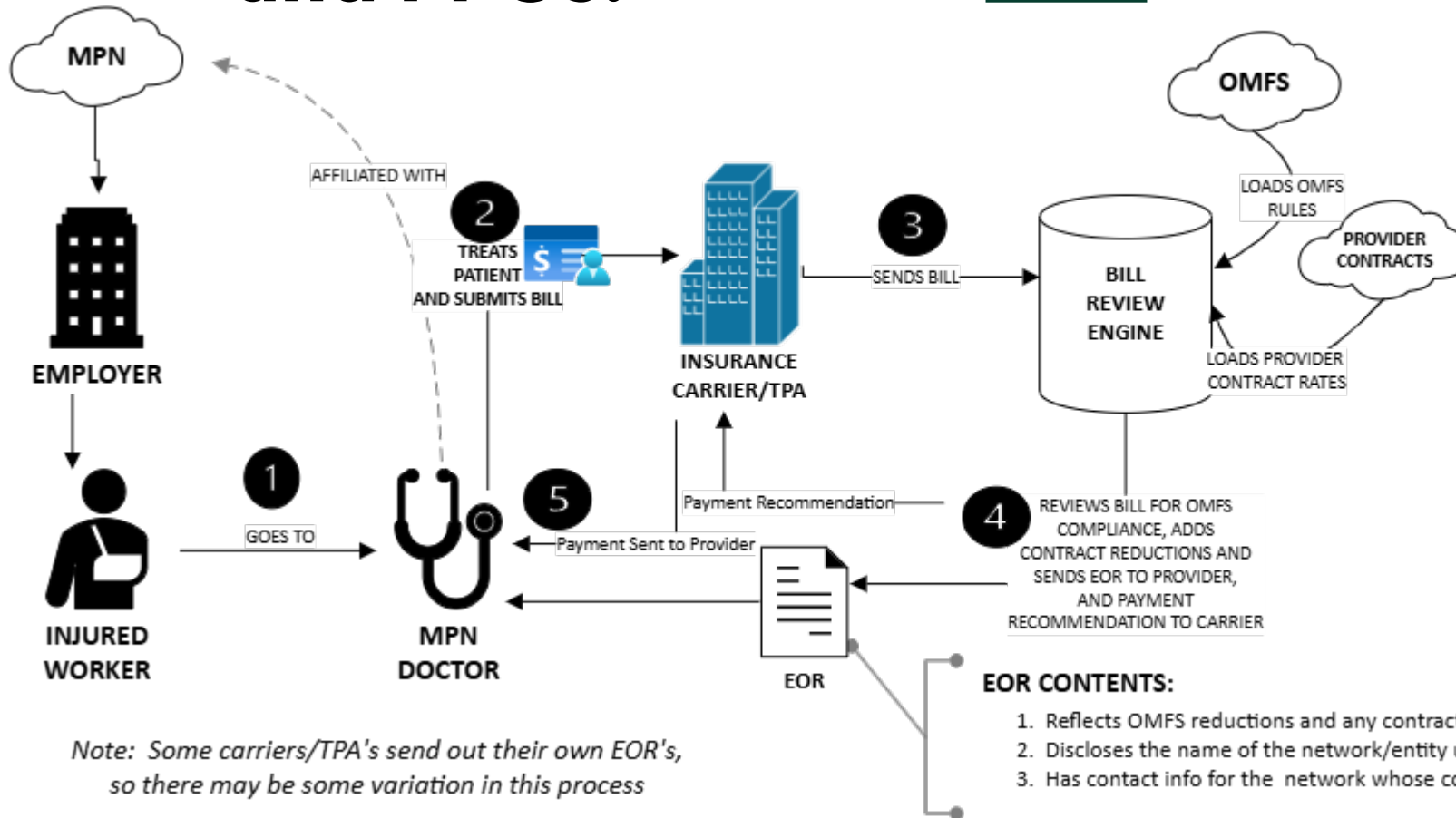
Medical & LAE Cost Components		
Changes to Lien Filings	-\$480	-2.5%
Spinal Implant Hardware Reimbursements	-\$110	-0.6%
Changes to Ambulatory Surgical Center Fees	-\$80	-0.4%
IMR Impact on Frictional Costs	\$70	0.4%
IBR Impact on Frictional Costs	\$0	0.0%
Medical Provider Network Strengthening	-\$190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

Source: 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



Although these terms are often used [incorrectly] interchangeably, they are **not synonymous**

Don't Confuse MPNs and PPOs!



Note: Some carriers/TPA's send out their own EOR's, so there may be some variation in this process

- **Medical Provider Networks (MPN's)** are a construct of the Labor Code (and DIR admin rules), and have specific access requirements, filing rules, etc.
- **Preferred Provider Networks (PPO's)** are a collection of *private contractual arrangements between providers and provider groups and various contracting entities*
- Many MPN's make use of underlying PPO's and other contracted organizations in order to meet their access standards
- Many providers sign *multiple* PPO contracts



Facts About PPOs (Did I mention that they are NOT THE SAME as MPNs!??)



Contract rates and terms are confidential, and requests for contract disclosures must be vetted appropriately



Network leasing arrangements allow providers to participate in multiple MPNs without re-contracting, upon signing of the Medical Provider Acknowledgement(s)



Current regulations already require disclosure of an underlying PPO network on an EOR when a bill has been repriced pursuant to a contract

NOTE: This information appears at the BOTTOM of EOR's, but some entities provide the contracting entity information closer to the top of the page in the corner



Provider participation in contracts is *voluntary*; providers may term their agreements at their will, often with 30-120 days' notice (depending on the contract)



Providers Are Able to Term Network PPO Arrangements

7.0 TERM AND TERMINATION

7.1 Term.

This Agreement begins on the Effective Date, continues for an initial term of two (2) years and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term, or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred twenty (120) days advance written notice to the other Party.

TERMINATION.

Termination Without Cause. Provider may terminate this Agreement at any time without cause by giving no less than ninety (90) days' prior written notice to [Network]. [Network] may, in its sole discretion, at any time during the Term, terminate this Agreement without cause and/or remove Provider from its Provider Network without cause and communicate such removal to Clients and/or Covered Individuals.

ARTICLE 9

TERMINATION OF AGREEMENT

9.1 Expiration of Agreement. Unless otherwise terminated as provided hereinafter, this Agreement shall continue in force as provided herein.

9.2 Termination Without Cause. With the exception of the revocation, suspension or restriction of Physician's Member's license to practice medicine, which would immediately terminate this Agreement upon provision of notice, the Agreement may be terminated with or without cause or penalty by Physician/Group or Organization at any time by giving thirty (30) days prior written notice to the other Party.



The Value of Networks in Workers' Compensation

In-Network Claims Are Tied to, Faster Access to Care, Shorter Recovery Times and Lower Costs



- **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
- **Shorter Disability and Faster Return to Work:** TD 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 PPD or lump-sum settlement payments
- **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
 - In-network claimants were 16% *less* likely to undergo major surgery and 17% *less* likely to receive pain management injections

[Source: Impact of Networks on Claim Outcomes, by Olesya Fomenko, Rebecca \(Rui\) Yang, Workers' Compensation Research Institute \(WCRI\), March 31, 2026](#)



The Value of Networks in Workers' Compensation (Cont'd)

In-Network Claims Are Tied to, Faster Access to Care, Shorter Recovery Times and Lower Costs

- **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).
- **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)
- **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%.

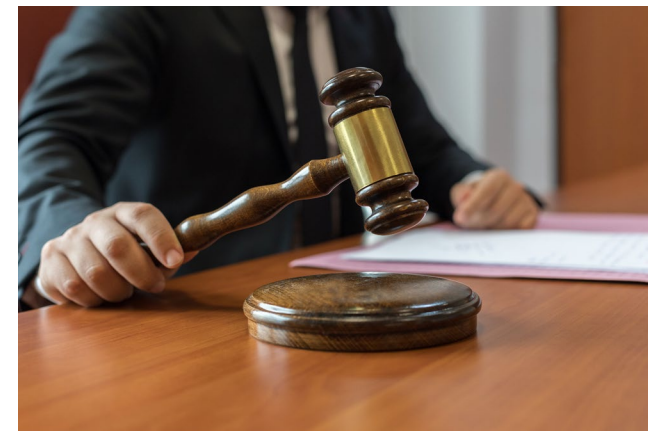


[Source: Impact of Networks on Claim Outcomes, by Olesya Fomenko, Rebecca \(Rui\) Yang, Workers' Compensation Research Institute \(WCRI\), March 31, 2026](#)



California's Fee Schedule; "Full Managed Care" Regulatory Framework Deliver Maximizes Network Benefits to Injured Workers

- **CA's "Low-Fee-Schedule Environment" Is Where Networks Deliver the Greatest Access Gains**
 - 27–28% faster time to first visit, and 30% more physical medicine utilization and reduced reliance on surgery
- CA'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*
- **CA's Regulatory Framework has all the recommended components to maximize the value to injured workers:**
 1. Time frame requirements
 2. Specialty coverage requirements
 3. Utilization review requirements
 4. Treatment guideline requirements



Source: Impact of Networks on Claim Outcomes, by Olesya Fomenko, Rebecca (Rui) Yang, Workers' Compensation Research Institute (WCRI), March 31, 2026



Contract-Related Friction is Minimal

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

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

- **99.96%** of bills moved through the system without triggering formal disputes
- IBR filings citing contractually related issues accounted for only **0.001236%** of total California bill volume



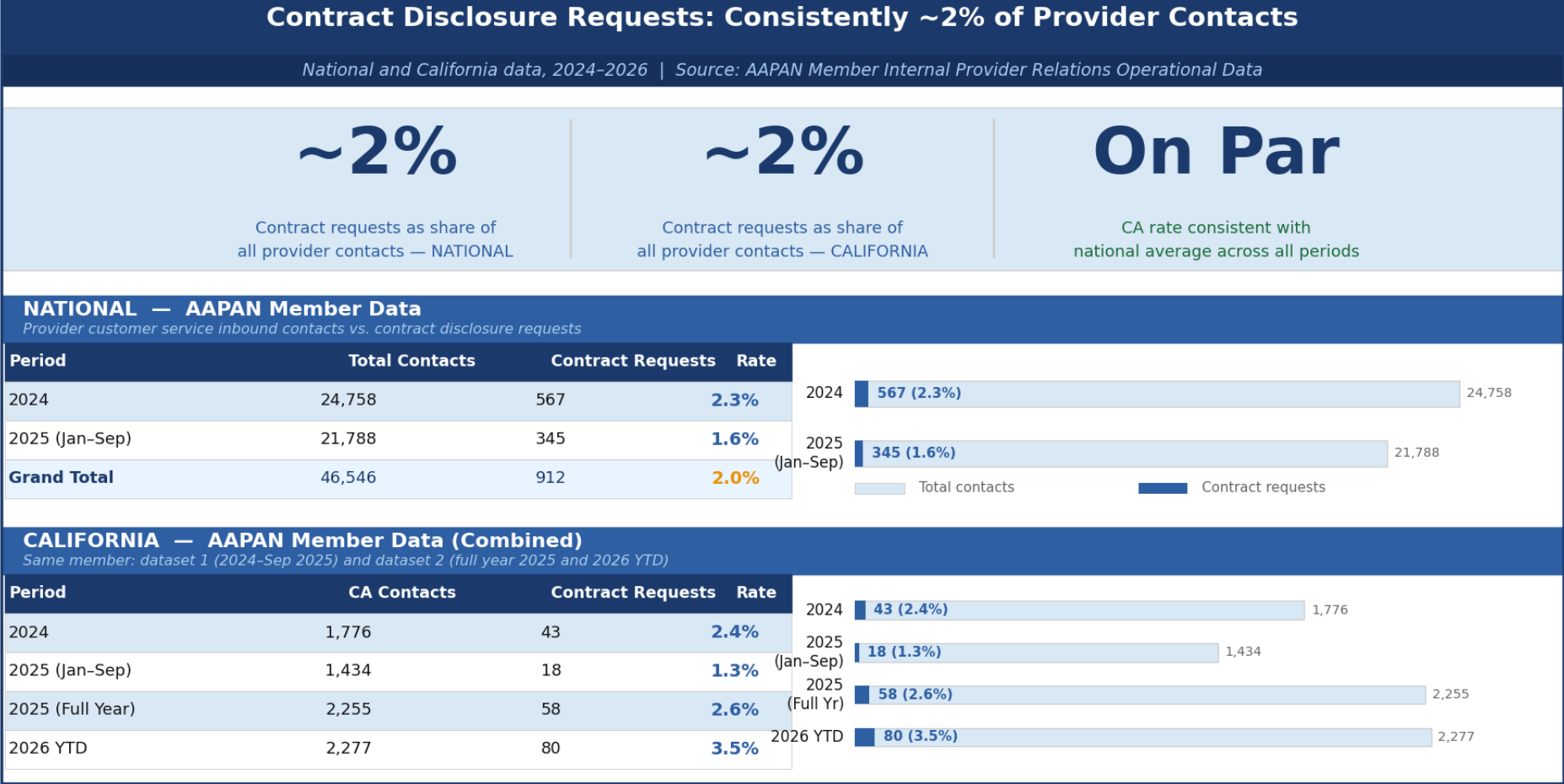
Contract-Related Friction is Minimal

Fee Schedule	Total Number in CY 2024	Total Number in CY 2025 <i>(through Aug.)</i>
Interpreter Services	2,598	1,996
Physician Services	748	692
Contract for Reimbursement Rates	136	139
Medical-Legal Fee Schedule	272	205
Hospital Outpatient Department & Ambulatory Surgical Centers	132	98
Pathology & Laboratory Services	42	36
Inpatient Hospital Services	25	34
Durable Medical Equipment, Prosthetics, Orthotics & Supplies	3	6
Ambulance Services	2	2
Pharmaceutical	-	1
TOTAL	3,958	3,209

Source:
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Volume of Contract Disclosure Requests Remains Low: California's Volume On Par With National Figures

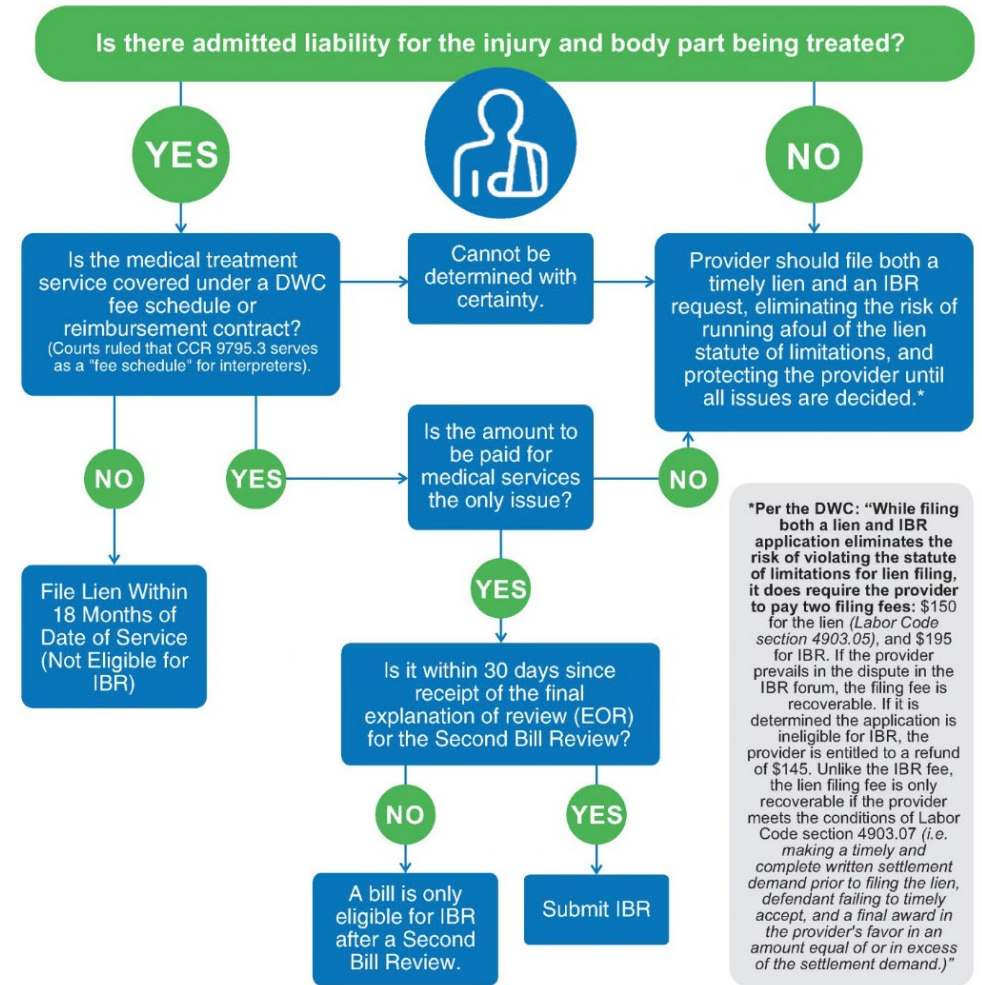


Ample Remedies Exist in WC Today for WC Bill Disputes

Applicability of a Contract is a “Threshold Issue” for IBR:

- If there is a question as to *whether* a contract applies to a disputed bill, that issue must first be resolved, either by:
 - Agreement of the parties that a contract exists and is applicable, OR
 - By determination of an ALJ
- Per CCR § 9792.5.7(d), an IBR request must include "if applicable, [the] relevant contract provisions for reimbursement rates under Labor Code 5307.11“
 - The provider must provide this documentation when filing for IBR after the threshold issue is resolved

INDEPENDENT BILL REVIEW VS LIEN FILING



Not to be construed as legal advice.

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Sample ADR Language

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



Ample Remedies Exist in WC Today for WC Bill Disputes

Additional administrative remedies include:

- Timely payment rules and late payment penalties for Medical-Legal bills and Treatment bills
- Sanctions for bad-faith actions (Labor Code § 5813)
- Penalties for unreasonable delay of benefits (Labor Code § 5814)



***Educational outreach opportunities are encouraged to inform providers of the remedies available to them**



Take-Aways...

- The statewide provider shortage is critical, impacts *all* healthcare delivery systems, and efforts are underway to address it
- The MPN's were historically created to address spiraling medical costs and escalating premiums, and the framework has delivered on those goals
- MPNs and PPOs are not synonymous, and understanding the differences is key when undertaking meaningful policy discussions
- **In-network claims outperform OON claims and provide more timely access to care, shorter disability durations, lower claim costs and lower litigation costs**
 - California's MPN regulatory scheme has **all 4 key aspects** cited by WCRI as factors that strengthen the value of networks for injured workers
- Contract-related friction is minimal, and adequate remedies exist for provider contract-related disputes



Thank you!

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