



IMPACT ANALYSIS REPORT

**AB 1465 and Medical Provider Networks  
in the  
California Workers' Compensation System**

**California Workers' Compensation Institute**

APRIL 2021



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## INTRODUCTION

Assembly Bill 1465 proposes that the California Division of Workers' Compensation (DWC) create an alternative medical provider network for injured workers, the California Medical Provider Network (CAMPN), with the stated intent of improving access to care. To analyze the likelihood that the proposed legislation could meet that goal, as well as the potential cost impact to the workers' compensation system, the authors reviewed a large sample of 2019 and 2020 work injury claims in which the injured workers were treated by medical provider network (MPN) and non-network providers and found little evidence of poor access to care in either group. In addition, the proposed statutes effectively neutralize contractual discounts, which could add \$286 million to the cost of medical care in the California workers' compensation system without improving access to care. The DWC's infrastructure costs to build and administer the CAMPN would likely add an additional \$13 million to \$65 million in expenses. System integration costs between payers and managed care companies and the DWC would result in significant additional expense, as would potential increases in medical utilization, attorney involvement, and medical dispute resolution.

The following report takes an in-depth look at the proposed legislation, the major impetus behind the proposal – injured worker access to care – and the cost of building and maintaining the California Medical Provider Network.

California Workers' Compensation Institute  
April 2021



## BACKGROUND

Assembly Bill 1465, sponsored by Assemblymembers Eloise Gómez Reyes and Lorena Gonzalez, asks the California Division of Workers' Compensation (DWC) to create an alternative medical provider network for the California workers' compensation system, called the California Medical Provider Network (CAMPN). The CAMPN will act as a wrap-around network giving injured workers the ability to use either: (1) their employer's MPN; or (2) the CAMPN. The stated legislative intent of the CAMPN is to improve access to care for injured workers. To evaluate the ability of the CAMPN to accomplish its legislative intent, it is helpful to review the role of physician networks in the California workers' compensation system and prior research on their effectiveness.

Physician networks have played an essential role in the California workers' compensation system for more than 35 years, beginning in the late 1980s when Preferred Provider Organizations were introduced into the system. Subsequent legislation and regulations created additional forms of physician networks, including Health Care Organizations (HCOs),<sup>1</sup> and in 2004, Medical Provider Networks (MPNs).<sup>2</sup> Legislators and regulators encouraged the proliferation and use of physician networks based on a body of research that showed an association between physician networks and better outcomes.<sup>3,4,5,6</sup> For injured workers, better outcomes meant higher quality of care through the use of scientifically proven, appropriate treatment and faster return to work. For payers, networks were associated with more consistent care, less litigation, lower costs, and fewer medical disputes. With these successes, the decades-long legislative intent to expand the use of networks was realized: in calendar year 1995, networks delivered approximately 35 percent of all workers' compensation medical treatment; by 2002, network penetration had grown to 44 percent; by 2011 it was 72 percent; and by 2020, approximately 90 percent of injured worker medical care was delivered through networks.<sup>7</sup> Since the DWC last adopted major changes to the regulations governing MPNs in August 2014,<sup>8</sup> medical costs have been relatively stable.<sup>9</sup>

Provider networks are designed and administered by managed care organizations or workers' compensation payers. Workers' compensation physician networks are comprised of providers who have significant experience treating injured workers as well as providers with expertise in generalized areas of medicine. MPNs must meet access to care standards for common occupational injuries and work-related illnesses set forth by the DWC.<sup>10</sup> Currently, there are approximately 114,000 licensed physicians in California, and approximately 51,000 (45 percent) treat workers' compensation patients.<sup>11</sup>

<sup>1</sup> Originally introduced in 1993, HCO use was also addressed in 2004's AB 749.

<sup>2</sup> SB 899, introduced in 2003-2004 legislative session, took effect 01/01/2005.

<sup>3</sup> Johnson, W. G., Baldwin, M. I. and Marcus, S. C. *The Impact of Workers' Compensation Networks on Medical Costs and Disability Payments*. Workers Compensation Research Institute (WCRI). November 1999.

<sup>4</sup> Swedlow, A. and Gardner, L. B. *Provider Experience and Volume-Based Outcomes in California Workers' Compensation – Does "Practice Make Perfect?"* CWCI Report to the Industry. February 2003.

<sup>5</sup> Victor, R.A. *The Impact of Initial Treatment by Network Providers on Workers' Compensation Medical Costs and Disability Payments*. WCRI. August 2001.

<sup>6</sup> Victor, R. A., Borba, P. S. and Want, D. *Provider Choice Laws, Network Involvement, and Medical Costs*. WCRI. December 2002.

<sup>7</sup> Ireland, J. Hayes, S. Swedlow, A. *PPO to MPN: Impact of Physician Networks in California Workers' Compensation*. CWCI Research Note, June 2015; CWCI 2021 (unpublished).

<sup>8</sup> Mandated by the 2012 reform bill (SB 863), the revisions to the MPN regulations adopted in August 2014 changed the requirements for developing, maintaining, and operating MPNs; revised notice requirements; added new penalty provisions; updated MPN access standards; and required MPNs to provide a medical access assistant to help injured workers access care.

<sup>9</sup> CWCI Claims Monitoring Application, Industry Claims Information System, Medical Payment Data Valued as of June 2020. WCIRB 2020 State of the System, Chart 29, Average Medical Cost Per Indemnity Claim, AY 1990-2019, July 2020.

<sup>10</sup> Lab. C. §4616(a)(1); 8 Cal. Code. Regs. §9767.5.

<sup>11</sup> Source: CWCI's IRIS database for medical services delivered between January 2019 and June 2020.



A substantial body of evidence from the group health sector has indicated a robust association between physician experience, measured by the volume of care provided, and the outcome of that care.<sup>12,13</sup> This concept of “volume-based outcomes” was the subject of a 2003 CWCI study, which showed that 89.8 percent of primary treating providers in the California workers’ compensation system 1 to 4 injured workers per year (or 14.4 percent of a study sample of more than 1 million claims). The balance of more experienced providers treated between 5 to 331 or more injured workers per year. After case-mix adjustment, outcomes for the claims involving the more experienced providers showed significantly less litigation, faster return to work, and lower average cost.<sup>14</sup> These studies illustrate the benefit in terms of quality outcomes for an injured worker to be seen by a provider that specializes in treating industrial injuries.

An important component of physician networks is the contractual relationship between the provider and the payer. In return for inclusion in a centralized network and for patient referrals, these physicians often agree to discounts from the Official Medical Fee Schedule (OMFS) rates for their services. Most providers belong to multiple networks with different contractual rates that vary by physician specialty, location, and other factors. When discounts are offered, they typically range from 10 percent to 17.5 percent below the OMFS rates. In return for price considerations, payers assist injured workers by matching their clinical needs to an appropriate network provider within an access-to-care standard established by the DWC. Networks must have sufficient providers to meet the California workers’ compensation system’s access standards, which require a choice of three general practitioners located within a 15-mile radius of an injured worker and three specialists located within a 30-mile radius. If the access standards cannot be met, injured workers may utilize non-network providers. In 2013, legislators and regulators further improved this system by requiring providers of MPNs to have Medical Access Assistants available to workers who might need assistance in finding the proper doctor for the right care.<sup>15</sup>

To safeguard the quality of care, network administrators also monitor physician utilization patterns against an evidence-based standard of care, California’s Medical Treatment Utilization Schedule (MTUS).<sup>16</sup> Referred to in statute as “economic profiling,” networks expend considerable effort and expense analyzing physician practice patterns against the MTUS to adjust their network composition. This is a common practice for almost all networks, not only in workers’ compensation, but also in group health and federal healthcare programs. This form of analysis is used to ensure that patients receive consistent, high quality, scientifically proven medical treatment at the agreed-upon pricing. In California workers’ compensation, variations in contractual pricing, the different locations of employers and employees, and the unique mix of injuries specific to individual industries led to the creation of individualized network solutions. Since the advent of MPNs in 2004, there have been 2,457 active medical provider networks.<sup>17</sup>

<sup>12</sup> (Hughes, Hunt and Luft, 1987). (Showstack et al., 1987). Luft, Bunker and Enthoven (1979) Hughes R. G., Hunt S. S. & Luft, H. S. *Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals*. Medical Care, 25:6:489-503, 1987.

<sup>13</sup> Showstack J.A., Rosenfeld, K. E., Garnick, D. W., Luft, H. S., Schaffarzick, R. W., & Fowles, J. *Association of Volume with Outcome of Coronary Artery Bypass Graft Surgery. Scheduled vs Nonscheduled Operations*. [erratum appears in JAMA 1987 May8;257(18):2438.]. JAMA, 257: 6: 785-9, 1987.

<sup>14</sup> Swedlow, A. and Gardner, L. B. *Provider Experience and Volume-Based Outcomes in California Workers’ Compensation – Does “Practice Make Perfect?”* CWCI Report to the Industry. February 2003.

<sup>15</sup> The Medical Access Assistant provisions of SB 863 were codified as Lab. C. §4616(a)(5), and 8 Cal. Code Regs. §9767.5(g) & (h).

<sup>16</sup> The Division of Workers’ Compensation established and updates the Medical Treatment Utilization Schedule, found at <https://www.dir.ca.gov/dwc/mtus/mtus.html>.

<sup>17</sup> The DWC’s list of MPNs is available here: [https://www.dir.ca.gov/dwc/mpn/dwc\\_mpn\\_main.html](https://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html).



## Preliminary Evaluation of the Impact of AB 1465

Assembly Bill 1465 seeks to create the California Medical Provider Network (CAMPN) for the workers' compensation system. The CAMPN will differ from the active California workers' compensation networks<sup>18</sup> in several ways:

- To start, the CAMPN will be comprised of licensed physicians in good standing with the California Medical Board (CMB) who are currently in any California workers' compensation network. Within 60 days of AB 1465's effective date, each employer, insurer, or private entity with an established MPN must turn over to the DWC Administrative Director a complete list of those physicians as of January 1, 2022. Eventually, the CAMPN seeks to include any licensed physician in good standing with the CMB. In its current form, AB 1465 does not address other physicians such as osteopaths, psychologists, chiropractic practitioners, and other ancillary service providers, as they are not licensed by the CMB.
- Payments for providers in the CAMPN will adhere to the maximum allowed amounts for services covered in the OMFS. This provision effectively negates long-standing network contractual agreements for price considerations below the OMFS.
- While all treatment delivered by the CAMPN will be subject to medical dispute resolution (Utilization Review & Independent Medical Review), evaluating provider performance to ensure that they are generally following treatment guidelines ("economic profiling") will not be permitted.

To better consider the purported improvements that the CAMPN will provide the California workers' compensation system against the effort and expense of building the CAMPN, the authors analyzed two areas:

- A. access to care; and
- B. the related cost and expenses of building and maintaining an alternative network free of agreed upon contractual discounts.

<sup>18</sup> Source: DWC as of January 2021 (<https://data.ca.gov/dataset/d607b6e5-3792-4403-8d0d-b16090d84ac0/resource/7a4fe0c3-68d4-4a18-bb3c-81fb7b2c1e32/download/mpnapprovedbydate.xlsx>).

**Access to Care**

Improving access to medical treatment is the central justification for AB 1465. To examine this issue, the authors measured current state access across two dimensions: (1) time to initiation of treatment; and (2) geographic proximity between the injured worker and the treating provider.<sup>19</sup>

1. Time to Initial Treatment

The authors used a database of 181,309 California workers’ compensation claims with dates of injury between January 2019 and June 2020 to determine the number of days between the date of employer notification of injury and the first date of medical treatment for claims managed by a network (MPN) physician versus those managed by a non-network (Non-MPN) physician.<sup>20</sup>

Exhibit 1: Average Days to Initial Treatment: MPN vs. Non-MPN Managed Claims

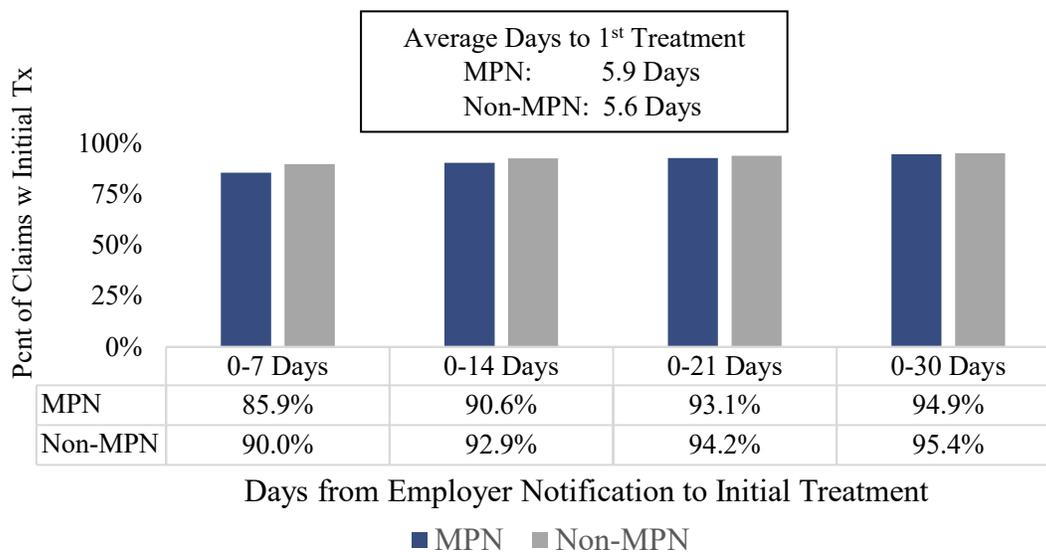


Exhibit 1 shows small differences in access as measured by the number of days from employer notice of injury to initial treatment. Within the first seven days, MPN claims had fewer claims receiving initial treatment than Non-MPN claims. That difference was largely resolved at two weeks following employer notification when more than 90 percent of all claims had received initial treatment. These findings suggest it is unlikely that the CAMPN would have a material impact on this access outcome.

2. Proximity Between Injured Worker and Treating Provider

Access to treatment is measured by the distance (mileage) for an injured worker to reach a given provider (*i.e.*, the distance from the injured worker’s home address ZIP code to the provider’s office). As in the time to treatment analysis, the authors used the sample of 181,309 claims with January 2019 through June 2020 injury dates to determine the injured workers’ proximity to three primary care physicians and three specialty physicians who treat injured workers. The primary care category focused on evaluation and management office visits from physicians in general practice, family medicine and occupational medicine, and specialist category focused on physicians performing surgical procedures. To allow for comparisons between those who were

<sup>19</sup> The authors used the Quest Analytics Suite (formally known as GeoAccess) to measure access to care.

<sup>20</sup> The authors employed an algorithm to measure the contribution of each provider on a claim to isolate that provider with the greatest degree of treatment control over the course of the claim along with their network affiliation (MPN or Non-MPN).



treated within a network and those who were not, the results were broken out separately for injured workers treated within an MPN and those who were treated outside an MPN.

Exhibits 2A and 2B show the injured workers’ access (in miles) to a choice of three workers’ compensation primary care physicians. In both the MPN and the non-MPN claim samples, nearly all of the injured workers had a choice of three workers’ compensation primary care physicians within 15 miles of their home, with 99 percent of the MPN patients and 98 percent of the non-MPN patients meeting the state’s access standard.

Exhibits 2A & 2B: Percent of Employees Meeting Access Standard & Average Distance to Initial Evaluation & Management Visit

Exhibit 2A: MPN Access

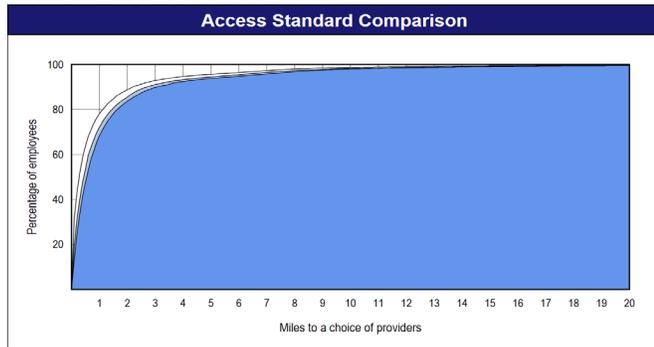
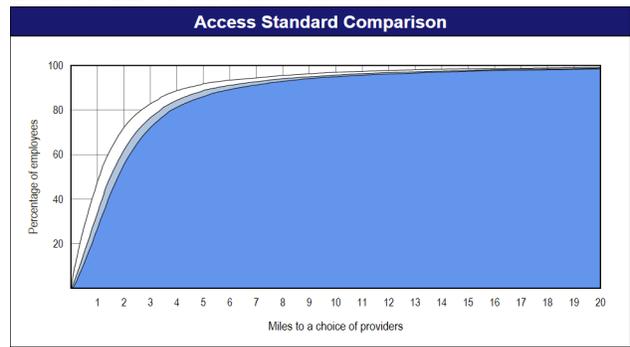


Exhibit 2B: Non-MPN Access



Percent of Claims Meeting Access Standard: 99%    Percent of Claims Meeting Access Standard: 98%

Exhibits 3A and 3B show injured workers’ access to a choice of three workers’ compensation surgery specialists. Once again, for both MPN and non-MPN managed claims, most injured workers (96 percent of those treated in MPNs, 95 percent of those treated outside an MPN) had a choice of three workers’ compensation surgeons within 30 miles of their homes.

Exhibits 3A & 3B: Percent of Employees Meeting Access Standard and Average Distance to Initial Surgery

Exhibit 3A: MPN Access

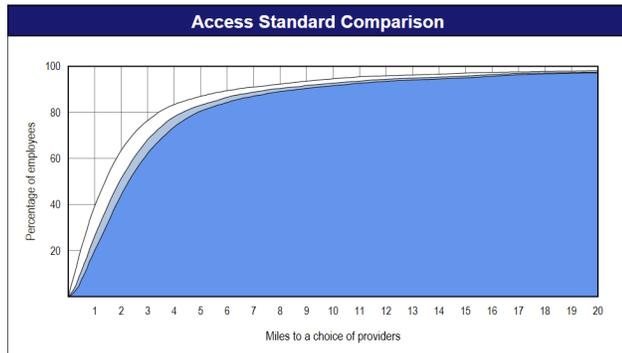
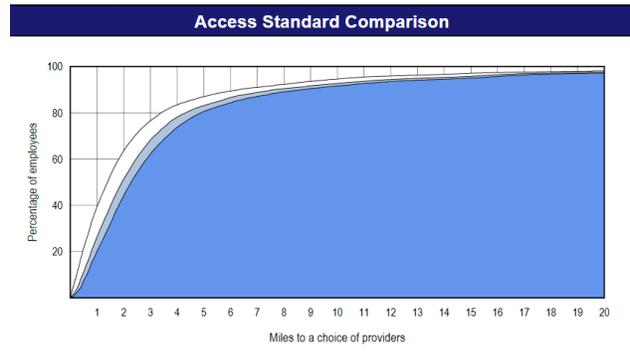


Exhibit 3B: Non- MPN Access



Percent of Claims Meeting Access Standard: 96%    Percent of Claims Meeting Access Standard: 95%

The combined results show that at least 95 percent of all injured workers in the accident year 2019-2020 study sample met the access standard for all combinations of MPN, Non-MPN, primary care, and surgery physicians.

While most Californians and most injured workers in the state are concentrated in and around major metropolitan regions, access to medical care in workers’ compensation, group health, or government



medical programs is heavily influenced by whether the patient lives in an urban, suburban, or rural area.<sup>21</sup> Exhibit 4 shows the average distance that injured workers living in urban, suburban, and rural areas of California needed to travel to see their workers’ compensation primary care or surgery provider, and once again for comparative purposes, the results are broken out for MPN and non-MPN patients.

Exhibit 4: Average Mileage between Injured Worker and Initial Treating Provider: Primary Care (Evaluation and Management Visit) and Surgery, MPN vs. Non-MPN Managed Claims

	<b>Miles from Injured Worker to Treating Provider</b>			
	<b>(Eval &amp; Management)<sup>22</sup></b>		<b>Surgery</b>	
	<b>MPN</b>	<b>Non-MPN</b>	<b>MPN</b>	<b>Non-MPN</b>
Urban	6.2	6.3	10.6	11.3
Suburban	8.2	7.6	11.7	12.7
Rural	12.1	12.3	13.0	13.1
<b>Grand Total</b>	<b>8.0</b>	<b>8.8</b>	<b>11.3</b>	<b>12.2</b>

Exhibit 4 notes differences in mileage between workers in urban, suburban, and rural regions, but shows only minor variations in access to primary care (E&M) services or specialty (surgical) services between MPN and Non-MPN patients within each regional category. Given the lack of significant difference in access, it is unlikely that an all-encompassing CAMPN will reduce proximity to care.

**The Cost of Building and Maintaining the CAMPN**

AB 1465 requires the DWC to construct the CAMPN. If enacted, regulatory details of managing the network will need to be codified. Under AB 1465, the CAMPN will include every licensed physician associated with any existing network in California serving workers’ compensation patients. Assuming that the CAMPN will resemble public and private sector networks, DWC will acquire responsibility for building and maintaining the inventory of providers. Among other administrative infrastructure and associated expenses, creating the network will require investigation, credentialing, and contracting of every provider. The DWC, for the first time ever, will have to create a significant infrastructure to build, analyze, and maintain such a network. To that end, the following cost estimate contemplates the two central areas of CAMPN management: contracting and credentialing; and infrastructure.

**A. Contracting and Credentialing:**

- Investigation & Application Processes
- Contracting
- Credentialing

Based on an estimated 51,000 providers who have treated one or more California workers’ compensation patients, and assuming that DWC staff will act as primary CAMPN administrators, a survey of managed care organizations and claims experts confirm an estimated cost of \$250 per contract.<sup>23</sup> This estimate includes staff time and other technical resources to gather and process personal and professional information on each physician candidate for the network. CAMPN estimates for contracting and credentialing are as follows: 51,000 providers x \$250/provider = \$12.8 million.

<sup>21</sup> Using U.S. Census data, the authors assigned each ZIP code as either urban, suburban, or rural based on their population statistics. An urban area is defined by a ZIP code population greater than 3,000 persons/square mile; suburban between 1,000 – 3,000 persons/sq mile; rural less than 1,000 persons/square mile.

<sup>22</sup> The claim sample for Evaluation and Management access used a database of 174,224 injured workers with an E&M initial visit and 31,919 claims with surgery. All claims had dates of injury between January 2019 and June of 2020.

<sup>23</sup> Average estimated cost from managed care organizations with broad-based MPNs.



**B. Infrastructure**

The DWC will require a significant investment in experienced staff and other resources to build and maintain the CAMPN. Without more regulatory details on the CAMPN’s architecture and resources, it is difficult to estimate infrastructure costs with any precision on the following requirements:

- Increased staffing (e.g., MPN contract managers and database programmers)
- Data processing systems and associated analytics
- Systems integration with Workers’ Compensation Information System medical bill review data
- Medical Access Assistant / Call Center services

Building and maintaining an infrastructure for ongoing management of a network is difficult to estimate given the unknown status of available staff (as well as their expertise in MPN contracting and management) and available and or scalable information systems technology. The authors surveyed large managed care organizations and estimated that administrative and technology expenses related to the CAMPN infrastructure would range from \$15 million to \$65 million per year.

**Additional Annual Costs from a Non-Discount Network**

Using WCIRB’s 2019 pre-pandemic insurer medical loss data, the authors identified eight medical loss categories that would incur additional costs from CAMPN’s elimination of contractual discount pricing:

Exhibit 5: Estimated Additional Medical Treatment Costs

	2019 Paid (\$ Millions) <sup>24</sup>	Costs Potentially Impacted by AB 1465 (\$ Millions)
1. Evaluation & Management	\$455.2	\$455.2
2. Surgery	\$155.6	\$155.6
3. Radiology	\$92.2	\$92.2
4. Medicine	\$62.0	\$62.0
5. Anesthesia	\$16.4	\$16.4
6. Other	\$1.8	\$1.8
7. Hospital – Outpatient	\$304.3	\$304.3
8. Medical Payments Direct to Injured Workers	\$1,469.8	\$734.9 <sup>25</sup>
<b>Total Provider Payments (Insurers)</b>	<b>\$2,557.3</b>	<b>\$1,822.3</b>

Self-Insured Provider Payments <sup>26</sup>	\$911.2
Total Insured and Self-Insured Provider Payments	\$2,733.5
Payments to MPN Providers (factor of 91% <sup>27</sup> )	\$2,487.5
Payments to MPN Providers subject to OMFS (factor of 92% <sup>28</sup> )	\$2,288.5
MPN Discount Rate <sup>29</sup>	12.5%
<b>Additional Annual Cost (based on 2019 expenses)</b>	<b>\$286.1 Million</b>

<sup>24</sup> Source: WCIRB 2019 California Workers’ Compensation Losses and Expenses. June 2020. Estimated costs are for the insurer market only. [https://www.wcirb.com/sites/default/files/documents/2019\\_ca\\_we\\_losses\\_and\\_expenses\\_report-complete.pdf](https://www.wcirb.com/sites/default/files/documents/2019_ca_we_losses_and_expenses_report-complete.pdf).

<sup>25</sup> Assumes conservative estimate that 50 percent of future medical settlements would be subject to OMFS.

<sup>26</sup> Public and Private Self-insured employers comprise approximately one-third of the California workers’ compensation system. To estimate self-insured payments, a factor of .5 was used against the insurer subtotal.

<sup>27</sup> CWCI IRIS data on 181k claims and associated medical bills found 91% of treatment costs were delivered by MPN providers.

<sup>28</sup> CWCI IRIS data on 181k claims and associated MPN medical bills found 92% of treatment costs were delivered by a MPN provider that offered a discount from the OMFS. This compares with similar analysis from three large MPN managed care administrators.

<sup>29</sup> Source: CWCI IRIS database and survey information from MPN providers.



The elimination of agreed-upon contractual discount considerations would have added approximately \$286 million or an additional 11.2 percent for the same treatment delivered in 2019. The CAMPN’s additional fees for such treatment would repeat each accident year. Note: these estimates do not include additional systems costs borne by insured and self-insured payers needed to create information technology integration platforms to access and share data with the CAMPN administrators.

**Estimated Cost of the CAMPN (\$ Millions)**

A. DWC	
Contracting and Credentialing:	\$12.8
Infrastructure:	\$15.0 – \$65.0
B. Insurers & Self-Insurers	
Additional Treatment Costs:	\$286.1
Systems Integration with CAMPN:	To Be Determined
	=====
	\$314M - \$364M

**DISCUSSION**

The legislative intent of creating the CAMPN is based upon the principled assertion that California’s injured workforce would benefit from greater access to treatment. The analysis presented above shows that the creation of the CAMPN would have both known and unintended consequences that limit its ability to achieve this goal.

**Known Consequences:**

- Little Likelihood of Improved Access to Care: Approximately 90 percent of workers’ compensation physician services are currently managed or delivered by MPNs. Prior legislation and regulations encouraged and achieved a broad proliferation of networks with various inventories of providers. As most networks are conceived and managed against specific California locations, industries, policyholder characteristics, and their associated employees and injuries, it is unlikely that an arbitrary increase in the sheer number of physicians will increase quality of care or MPN utilization and access beyond current levels.
- New DWC Infrastructure Costs: The DWC has never been compelled to create a statewide network. Starting from scratch would require wholesale investments in experienced staff, establishment of elaborate contracting and credentialing processes, creation of information systems and analytics, and interfacing with all payers and employers. A contracted and credentialed CAMPN with 51,000 providers will take years to assemble and cost the state an estimated \$15 million - \$65 million per year.
- Additional Cost of Care: By negating existing contractual agreements on price considerations, the California workers’ compensation system will incur an additional \$286 million per year (based on 2019 medical losses) in medical provider treatment costs.
- A combined initial cost estimate of \$314+ million per year is unlikely to improve access to care.



## Unintended Consequences:

Beyond the additional cost of care and administration expenses outlined above, there will be other costs. Expanding networks without the benefit of contractual prices or the ability to analyze practice patterns will likely lead to increases in known cost drivers, the degree to which is beyond the bounds of this preliminary analysis.

Since the 2003-2004 reforms, legislative and regulatory reforms have increased access to care through the use of medical provider networks as a medical delivery component that could consolidate treatment and increase quality of care with experienced providers well versed in the rules and regulations that not only guide medical decision making but also facilitate return to full function. Since 2004, 2,457 MPNs have been serving injured workers and have increased their utilization to 90 percent of key outpatient services.

Future CWCI research will examine MPN managed claims in the following areas:

- Changes in medical utilization
- Attorney involvement & medical-legal evaluation
- Medical dispute resolution (utilization review, independent medical review, independent bill review)
- Return-to-work

### California Workers' Compensation Institute

The California Workers' Compensation Institute (CWCI), incorporated in 1964, is a private, nonprofit membership organization of insurers and self-insured employers. CWCI conducts and communicates research and analyses to improve California's workers' compensation system. CWCI members include insurers that collectively write 80 percent of California's workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's website, [www.cwci.org](http://www.cwci.org).

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### California Workers' Compensation Institute

1333 Broadway, Suite 510, Oakland, CA 94612 | 510-251-9470 | [www.cwci.org](http://www.cwci.org)

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