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**SENATE COMMITTEE ON LABOR, PUBLIC EMPLOYMENT AND RETIREMENT**  
**Senator Lola Smallwood-Cuevas, Chair**  
**2025 - 2026 Regular**

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**Bill No:** AB 1048 **Hearing Date:** June 10, 2026  
**Author:** Chen  
**Version:** January 22, 2026  
**Urgency:** No **Fiscal:** Yes  
**Consultant:** Jazmin Marroquin

**SUBJECT:** Workers' compensation

**KEY ISSUE**

This bill makes changes within the workers' compensation medical billing process requiring employers to include specified information on an underlying contract to justify a discount, as specified, as well as include the contact information where a provider may obtain a copy of such contract. The bill additionally prescribes an alternate payment rate for services if the contract is not sent to a provider within 30 days of the request, as specified.

**ANALYSIS**

**Existing law:**

- 1) Establishes a comprehensive system of workers' compensation that provides a range of benefits for an employee who suffers from an injury or illness that arises out of and in the course of employment, regardless of fault. This system requires all employers to ensure payment of benefits by either securing the consent of the Department of Industrial Relations (DIR) to self-insure or by obtaining insurance from a company authorized by the state. (Labor Code §§3200-6002)
- 2) Requires an employer to provide an Explanation of Review (EOR), upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, in the manner prescribed by the administrative director (AD) of the Division of Workers' Compensation (DWC) that must include all of the following:
  - a) A statement of the items or procedures billed and the amounts requested by the provider to be paid.
  - b) The amount paid.
  - c) The basis for any adjustment, change, or denial of the item or procedure billed.
  - d) The additional information required to make a decision for an incomplete itemization.
  - e) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
  - f) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review must inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill, as specified. (Labor Code §4603.1)

- 3) Allows the AD to adopt regulations requiring the use of electronic EOR. (Labor Code §4603.1)
- 4) Specifies, that in order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel must be disclosed by the contracting agent to the provider in advance and must actively encourage employees to use the network, unless the health care provider agrees to provide discounts without that active encouragement. (Labor Code §4609)
  - a) Requires, beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as specified, or another contracting agent to, upon entering or renewing a provider contract, do all of the following:
    - i) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.
    - ii) Disclose what specific practices, if any, payors utilize to actively encourage employees to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate, as specified.
    - iii) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the employees to use the list of contracted providers when obtaining medical care, as specified.
    - iv) Disclose, upon the initial signing of a contract, and within 15 business days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.
    - v) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care, as specified. Specifies that each provider's election is binding on the contracting agent with which the provider has the contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers.
    - vi) Prohibits a provider from being excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors *that actively encourage* the employees to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors *that do not actively encourage* the employees to use the list of contracted providers when obtaining medical care.

- b) Specifies that if the payor's explanation of benefits or EOR does not identify the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered, the contracting agent must do the following:
  - i) Maintain a Web site that is accessible to all contracted providers and updated at least quarterly and maintain a toll-free telephone number accessible to all contracted providers whereby providers may access payor summary information.
  - ii) Disclose through the use of an Internet Web site, a toll-free telephone number, or through a delivery or mail service to its contracted providers, within 30 days, any sale, lease assignment, transfer or conveyance of the contracted reimbursement rates to another contracting agent or payor.
- c) Requires, a payor, as specified, beginning July 1, 2000, to do all of the following:
  - i) Provide an explanation of benefits or EOR that identifies the name of the network with which the payor has an agreement that entitles them to pay a preferred rate for the services rendered.
  - ii) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor.
    - (1) Requires the provider to include in the request a statement explaining why the payment is not at the correct contracted rate for the services provided.
    - (2) Specifies that failure of the provider to include a statement relieves the payor from the responsibility of demonstrating that it is entitled to pay the disputed contracted rate.
    - (3) Specifies that failure of a payor to make the demonstration to a properly documented request of the provider within 30 business days renders the payor responsible for the lesser of the provider's actual fee or, as applicable, any fee schedule pursuant to this division, which amount will be due and payable within 10 days of receipt of written notice from the provider, and will bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate, as specified.
    - (4) A payor will be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:
      - (a) Describes the specific practices the payor utilizes, as specified.
      - (b) Identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contracted providers, as specified.
- 5) Requires each employer to establish a utilization review process, as specified, either directly or through its insurer or an entity with which an employer or insurer contracts for these services. (Labor Code §4610)
- 6) Requires the AD to, after public hearings, adopt and revise periodically an official medical fee schedule (OMFS) that establishes reasonable maximum fees paid for medical services provided to workers' compensation patients. (Labor Code §5307.1)

- 7) Authorizes a medical provider and a contracting agent, employer, or carrier to contract for reimbursement rates that differ from the OMFS, so long as those rates do not exceed the rates established by the OMFS. (Labor Code §5307.11)

**This bill:**

- 1) Requires employers to additionally include the following information in their Explanation of Review (EOR), upon payment, adjustment, or denial of a complete or incomplete itemization of medical services:
  - a) The state assigned medical provider network identification number applicable to the bill.
  - b) If the adjustment, change, or denial is based on a contract, then the EOR must include specific information on the underlying contract that was relied upon to justify the discount and contact information, including an address and email address for whom the rendering medical provider may contact to receive a copy of the underlying contract.
    - i) Provides that for the purposes of this section, the “underlying contract” is the contract associated with the tax identification number of the rendering medical provider and the medical provider network listed on the explanation of review.
    - ii) Specifies that disclosure of a medical provider network does not satisfy this requirement.
    - iii) Specifies that only the rendering provider or their agent shall be provided a copy of the underlying contract within a 365-day period.
    - iv) Requires the medical bill to automatically be reprocessed and paid at the rates mandated by the OMFS, if the contract is not sent to the rendering provider or their agent within 30 businesses days of the provider’s request.
- 2) Allows the AD to adopt regulations as necessary to implement the provisions of this section, as specified.
- 3) Additionally requires the request for authorization for medical treatment to be signed by the treating physician and may be mailed, faxed, or sent electronically through the use of a secure email system or via electronic data interchange to the address, fax number, email address, or clearinghouse designated by the claims administrator.

## COMMENTS

### 1. Background:

#### Workers’ compensation billing

Under the California workers’ compensation system, if a worker is injured on a job, the employer must pay for the worker’s medical treatment and provide monetary benefits if the injury is permanent or temporarily results in lost wages. In return for receiving free medical treatment, the worker surrenders the right to sue the employer for monetary damages in civil court. In California, all employers are required to either purchase a workers' compensation insurance policy from a licensed insurer authorized to write policies in California or become self-insured.

The workers' compensation system has several formal mechanisms for resolving disputes regarding the details of the injury, the medical necessity of aspects of the treatment plan, or the billing of insurers by medical providers that involve qualified medical evaluators (QMEs), workers' compensation administrative law judges, and the Workers' Compensation Appeals Board (WCAB), among others.

When a medical provider and an employer or insurer disagree on payment for medical services provided, the medical provider can submit the bill to the insurance claims administrator for a second bill review, with any remaining dispute resolved through the independent bill review (IBR) process. The only issue addressed during the IBR process is the amount to be paid for the medical service provided.

The official medical fee schedule (OMFS) establishes the maximum allowable fees to be paid to a medical provider for medical services provided to a workers' compensation patient. DWC updates the OMFS annually, but there are often mid-year changes as necessary to conform to relevant Medicare and Medi-Cal changes. However, existing law also authorizes a medical provider and a contracting agent, employer, or insurer to contract for a reimbursement rate that differs from the OMFS, as long as the contracted rate does not exceed the OMFS rate.

Medical providers in the workers' compensation system do not typically bill for services at the rate set for OMFS, instead they bill at their "usual and customary" rate for services and then claims administrators must accurately adjust those bills to reflect the OMFS, or their applicable contracts. When the adjustment is done and the payment is made, an Explanation of Review (EOR) is given to the provider explaining any adjustments, changes, or denials to the fee schedule or contracted network rate.

#### Medical Provider Networks

A medical provider network (MPN) is a group of health care providers set up by an insurer or by an entity that provides physician network services and approved by DWC's administrative director to treat workers injured on the job. Each MPN includes a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. Employees covered by an MPN will be taken care of by doctors in the network unless they were eligible to pre-designate their personal doctor and do so before their injury happened.

#### Preferred Provider Organization (PPO) Discounting

Under an arrangement known as a Preferred Provider Organization (PPO), the insurer sends business to the medical provider, and in exchange, the medical provider offers services for a discounted rate to the insurer. However, this system has also given rise to a practice known as "silent PPO discounting."

Silent PPO discounting is when the PPO sells or leases to other insurers its provider list, including discounted rates the PPO has brokered on behalf of an insurer to use these providers. In many instances, the providers have no knowledge and never intended to extend their discounts to these additional insurers.

To address the practice of silent PPO discounting, or improper selling, leasing or transferring of a health care provider's contract, existing law requires contracting agents to disclose

network leasing arrangements *in advance* by the contracting agent to the medical provider.<sup>1</sup> Payors (insurers) also must provide an explanation of benefits or EOR that identifies the name of the network that the payor has an agreement with that entitles them to pay a preferred rate for the medical services rendered.

A payor must additionally demonstrate that it has the right to pay a contracted rate within 30 business days of a written request from a medical provider. The provider must include in the request a statement explaining why the payment is not at the correct contracted rate. If the provider does not include a statement, this relieves the payor from demonstrating that it has the right to pay the disputed contracted rate. If the payor does not meet the 30-day deadlines, the payor is responsible for the provider's actual fee or, as applicable, any fee schedule, whichever is less, and needs to be paid within 10 days of receipt of written notice from the provider. The payor also is not allowed to take any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate. It is unclear if in practice, network leasing arrangements are properly disclosed to providers as required by law.

## 2. Need for this bill?

According to the author, "AB 1048 addresses unauthorized discounts and reductions on medical treatment bills in the workers' compensation system by ensuring providers have a clear and enforceable way to challenge improper payment reductions.

Current law does not clearly address situations where third-party network administrators apply additional, unauthorized discounts through "silent" Preferred Provider Organization (PPO) arrangements. Although providers may agree to specific contractual discounts, those agreements are sometimes sold or leased to other entities, resulting in further payment reductions without the provider's knowledge or consent.

For example, a San Diego orthopedic surgeon received \$548.54 for a procedure that carries a \$672.50 standard reimbursement under the Official Medical Fee Schedule. The discount was applied without explanation or agreement. She is now the only physician in her practice still treating injured workers, illustrating how these practices can drive providers out of the system. Without clear disclosure requirements or enforcement mechanisms, providers lack the information necessary to determine whether payment reductions are valid or to effectively challenge them.

AB 1048 improves transparency and accountability by establishing clear rules for contract-based payment reductions. When a payment is reduced based on a contract, the Explanation of Review must include specific information about the underlying contract and provide contact information for obtaining a copy.

The bill gives providers and their authorized agents the right to request –only once in a 365 day period - the contract used to justify a discount. That contract must be provided within 30 business days. If it is not, the claim must be automatically reprocessed and paid at the Official Medical Fee Schedule. By improving payment certainty and fairness, the bill supports continued provider participation and helps preserve injured workers' access to timely, high-quality care.”

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<sup>1</sup> Labor Code §4609

### 3. Proponent Arguments:

According to the California Orthopaedic Association, the sponsors of this bill:

“AB 1048 (Chen), which will bring greater transparency and fairness to medical treatment payment disputes within California’s Workers’ Compensation system. [...] Unfortunately, physicians are increasingly facing unexplained or unauthorized reductions in payment, often through leased-network arrangements. In these situations, a provider may agree to a specific contractual discount with one entity, only to later see that contract sold, leased, or accessed by other entities that apply additional discounts without the provider’s knowledge or consent. The Explanation of Review may identify a payment reduction but fails to provide enough information for the provider to determine whether the reduction is valid, contractually authorized, or improperly taken. If a payment is reduced based on a contract, the provider should be able to identify the applicable contract and review the terms being relied upon. Without that information, the provider cannot meaningfully evaluate whether the payment was correct, request appropriate review, or challenge an improper discount.

AB 1048 provides a reasonable and targeted solution. When an adjustment, change, or denial of a workers’ compensation medical bill is based on a contract, the bill requires the Explanation of Review to include specific information about the underlying contract and contact information for obtaining a copy of that contract. To ease the burden on those required to produce the contract, AB 1048 includes practical safeguards by limiting the requirement to produce the requested contract to only once within a 365-day period and allowing up to 30 business days for this contract to be provided. If the contract is not provided within that timeframe, the payment would simply be reprocessed and paid at the rates mandated by the Official Medical Fee Schedule. To be clear, AB 1048 does not prohibit or reverse legitimate contracted discounts. It simply ensures that when a discount is given, the entity taking that discount can identify and produce the contract that authorizes it. This bill is simply about basic transparency and accountability within the payment process.”

### 4. Opponent Arguments:

According to the opponents, which includes the American Property Casualty Insurance Association, and a large coalition of businesses, insurers, and counties:

“We are not opposed to providing a method by which providers can receive a copy of the applicable contract. In fact, we have proposed a version of this same policy, but the approach taken in AB 1048 creates new problems:

Creates Loophole Allowing Providers to Get Around Mutually Agreed Upon Terms of a Contract - As drafted the bill would allow providers to request a copy of the contract with every EOB, understanding that “late” delivery of the contract would invalidate their contracted discount and result in a higher payment. Providers in the workers’ compensation system are highly educated and intelligent professionals who do not need the protection of the state with regards to these mutually agreed upon contracts. Unfortunately, there are some providers in the workers’ compensation system who have a long and storied history of relentlessly exploiting narrow administrative loopholes for financial gain. Just in the last decade the legislature has had to address widespread abuse in drug repackaging, spinal surgery implant reimbursements, and even the mundane lien process. We expect that a small

but impactful number of doctors will relentlessly abuse this loophole if implemented in its current form. This will result in higher costs for the system, which means higher workers' compensation premiums for all employers in California. On the other side, the sponsors have presented one anecdotal story but have no industry-wide data to show a need AB 1048 in its current form.

The Penalty is Inappropriate – Providers sign contracts to serve network patients at a discounted rate because they benefit from the steady stream of patient referrals. They have a duty to track their own contractual relationships and understand the agreements they have made. While we do not mind sending these providers copies of the contracts they've entered, we don't think we should be financially penalized for late delivery of legal documents these providers should already have. Moreover, those providers have already received the benefit of the bargain under their contracts (e.g., steering of injured workers to the provider as part of an MPN) and are now trying to eliminate their obligations under the contract (i.e., the discount).

Allows Unlimited Copies of Contracts – As drafted, a provider could request a copy of the same contract repeatedly without limitation. There is no reason that networks should be required to provide repeat copies of contract to providers who in fact already have them. We propose limiting providers to one copy of each contract to which they are a party in each calendar year. This would keep requests at a reasonable volume and prevent a small number of providers from abusing the system.”

According to the American Association of Payers, Administrators and Network, who write in opposition, unless amended:

“While we believe AB1048 was well-intentioned, the legislation as written oversteps existing contractual provisions, mandates irrelevant data on the Explanation of Review (EOR), and risks contract disclosures to inappropriate parties. [...] The preferred provider organization (PPO) relationship between payors and healthcare providers is governed by contracts, which have been mutually negotiated in good faith. Providers often accept discounts off their billable rates in exchange for networks directing business to the practices via a combination of methods including Medical Provider Network (MPN) provider directories, claims adjuster referrals, and Medical Access Assistant (MAA) referrals. AB1048 ignores these contractually agreed upon discounts and allows providers to side-step agreements that they have already signed and benefitted from due to payor customer service shortcomings. We have shared this concern with the author's office and noted that the bill must be amended to strike Section 4603.3(a)(4)(F). AB 1048 destabilizes the provider contract negotiation process and incentivizes providers to request contract disclosures in the sole hopes of trying to force reimbursement at higher rates than their contract allows.”

## 5. Committee Comments:

This bill, AB 1048, aims to address discounts and reductions in medical treatment bills in the workers' compensation system. The bill would require the EOR sent by employers to medical providers to also include specific information about the underlying contract that was relied upon to justify any discounts if the adjustment, change, or denial of an itemization of medical services is based on a contract. The bill also requires the EOR to include an address and email address for whom the rendering medical provider *may* contact to get a copy of the underlying contract.

Committee amendments

As mentioned, existing law already requires contracting agents (or payors) to disclose network leasing arrangements, also known as silent PPO discounts. Payors also must provide an EOR that identifies the name of the network that the payor has an agreement with that entitles them to pay a discounted rate for medical services, and must demonstrate that it has a right to pay the discounted contracted rate if a medical provider provides a written request and a statement explaining that the payment is not at the correct contracted rate. Without the written request and statement from the provider, the payor does not have to demonstrate anything. But with the request and statement from the provider, the payor has 30 business days to demonstrate it is entitled to pay a discounted rate. If not, the payor is responsible for paying for the provider's actual fee or any specified fee schedule, whichever is less, within 10 days of receipt of the provider's written notice.

The existing law provisions may sound a lot like the proposed bill. Proponents claim that the disclosure requirements are not enforced, and that existing law is not working the way it was designed. This bill attempts to remedy that by requiring the EOR to also include information about the underlying contract that was relied upon to justify a discount and contact information so that a provider may contact someone to receive a copy of the contract. According to the proponents of the bill, AB 1048, does not prohibit or reverse legitimate contracted discounts. They argue it simply ensures that when a discount is taken, the entity taking that discount can identify and produce the contract that authorizes it. If the payor fails to produce the contract within 30 days of the request, the payor will be responsible for the payment set at the OMFS rate. If the payor can produce the contract that shows the discount, the discounted payment will stay the same.

For clarity and consistency, the requirements under this bill should be incorporated in Labor Code Section 4609 where the network leasing arrangement disclosures and requirements for payors and providers currently exist, therefore ***the author has agreed to committee amendments that instead incorporate the contents of this bill, AB 1048, to Labor Code Section 4609.***

The author and sponsors also claim their intent with AB 1048 is to give medical providers and their authorized agents the right to request – only once in a 365-day period – the contract used to justify a discount. However, it is not clear that the providers can only request the contract be sent to them once per year. ***The author has agreed to make a clarifying amendment to the bill to specify that upon request, the rendering provider or their agent shall be provided with a copy of the contract only once per year.***

**6. Prior Legislation:**

SB 668 (Hurtado, 2025) would have authorized the DWC AD to adjust the fee schedule for medical-legal evaluations every two years based on an evaluation of medical practice costs. *This bill was held under submission in the Senate Appropriations Committee.*

SB 863 (De Leon, Chapter 363, Statutes of 2012) enacted major reforms to the workers' compensation system, including establishing the independent medical review and IBR processes for resolving disputes.

**SUPPORT**

California Orthopaedic Association (Sponsor)  
California Medical Association (CMA)  
California Podiatric Medical Association  
Peace Officers Research Association of California (PORAC)

**OPPOSITION**

American Association of Payers Administrators and Networks  
American Property Casualty Insurance Association  
California Association of Joint Powers Authorities  
California Chamber of Commerce  
California Coalition on Workers Compensation  
California Food Producers  
California Joint Powers Insurance Authority  
California League of Food Producers  
California State Association of Counties  
Public Risk Innovation, Solutions, and Management (PRISM)  
Schools Excess Liability Fund (SELF)  
Urban Counties of California (UCC)

**-- END --**