American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

January 22, 2026

The Honorable Brett Guthrie
Chair
House Committee on Energy and Commerce
2125 Rayburn House Office Building

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
2323 Rayburn House Office Building

The Honorable Jason Smith
Chair
House Committee on Ways & Means
1139 Longworth House Office Building

The Honorable Richie Neal
Ranking Member
House Committee on Ways & Means
1129 Longworth House Office Building

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Smith, and Ranking Member Neal:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding these important hearings on lowering health care costs for Americans by carefully examining the affordability of health care insurance and the role of large insurance companies in growing costs and rising premiums. We deeply appreciate this joint effort to help shed light on practices contributing to surging health care costs and are grateful for the opportunity to share our comments for the record.

Whether through explicit violations of the No Surprises Act, abuse of prior authorization procedures, frequent attempts to undermine and erode the federal prudent layperson standard, or outright denials of necessary care, insurers continue to exploit our health care system and the individuals and families they ostensibly cover, all for the sake of increasing record profits. ACEP strongly supports the enforcement of laws and regulations meant to halt these patterns of bad behavior that have only become more egregious over the course of recent years.

Emergency physicians provide care under circumstances and laws that are unique among other physician and provider specialties. We provide more uncompensated care than any other physicians, as the federal Emergency Medical Treatment and Labor Act (EMTALA) requires that anyone coming to an emergency department (ED) must be stabilized and treated, regardless of their insurance status or ability to pay. The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. A report issued by RAND in April 2025, "Strategies for Sustaining Emergency Care in the United States,"[1] brings this uncompensated care

[1] https://www.rand.org/pubs/research_reports/RRA2937-1.html

burden into sharp relief – across all payers, 20 percent of emergency physician payments go unpaid, representing $5.9 billion in annual losses. Additionally, in order to ensure 24/7/365 access to the emergency department, we work under more specialized staff and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, mental health conditions, and countless others. Unfortunately, many insurers continue to exploit these unique circumstances that harm physician practices and put patients at risk.

Violations of the Federal Prudent Layperson Standard & "Downcoding"

For more than twenty years, the prudent layperson standard (PLS) has protected patients from being subjected to retroactive denials by health insurers. This straightforward law importantly recognizes that patients should not be afraid to visit the ED for fear their insurance will not cover their visit – if you think you are having a medical emergency, you should seek emergency care. However, this has not stopped health plans from trying to skirt the law, using scare tactics to prevent people from seeking emergency care, and denying or downcoding claims based on final diagnoses rather than the presenting symptoms that initially brought the patient to the ED seeking treatment.

In 2017, Anthem Blue Cross Blue Shield Healthcare Plan of Georgia instituted its "avoidable ER" program in order to "prevent in appropriate use of the ER for non-ER care, and to encourage members to connect with their primary care providers, use telehealth, or visit urgent care for non-emergency conditions to promote a comprehensive approach to care." Anthem also implemented this policy in Kentucky, Missouri, Ohio, Indiana, and New Hampshire. In some of the affected states, Anthem notified enrollees via letters that stated "Save the ER for emergencies – or you'll be responsible for the cost." Under the policy, patients who sought emergency care were responsible for paying their entire bills if Anthem determined that their diagnoses were not "true" emergencies after a retrospective review.

Such a policy is particularly dangerous as it discourages people from seeking medical care – expecting patients to determine what symptoms are life-threatening or not, and punishing them financially if they are wrong. Additionally, a fundamental component of emergency medicine is ruling out life-threatening conditions, which requires a careful history and physical examination by a physician familiar with such ailments. Every day, emergency physicians treat patients who have identical symptoms but *very* different conditions – some patients may be able to be sent home, some may need a medical procedure, and some may need to be admitted to the hospital. This is a clinical determination that can only be made after a full medical work-up. Patients should not be expected to make this determination, nor should they be penalized after the fact by their insurer who denied coverage simply because the final diagnosis did not turn out to be an emergency. While Anthem ultimately discontinued this policy in 2022, other insurers, such as United Healthcare in 2021, continue to attempt to chip away at the critical patient protections established by the federal prudent layperson standard.

In the latter half of 2020, Anthem Blue Cross California began to deny payment to many small emergency physician groups in the state for the care they provided to patients with the highest acuity conditions, such as heart problems, severe kidney infection with sepsis, seizures, and others. These denials occurred throughout the state at different hospitals staffed by different emergency physician groups, regardless of whether they were in- or out-of-network with the health insurer.

As background, there are five levels of ED care, documented and billed for using Current Procedural Terminology (CPT) codes 99281-99285. These ED codes require all three key components (patient and family history, a physical examination, and the physician's medical decision-making) to be met and documented for the level of service billed in the emergency physician's claim. Patients are required to be categorized based on the severity of their presenting problem(s): for example, a Level 4 (99284) visit is a severe problem that requires urgent evaluation that will, without treatment, have a high chance of extreme impairment (however, does not pose an immediate threat to life or to physical function. A Level 5 (99285) visit, on the other hand, is an immediate, significant threat to life or physiologic functioning. An additional point to be aware of is that emergency physician services are billed separately by the physician group from the facility fee, which is billed by the hospital.

It was care provided in these most severe cases that Anthem refused to pay at all. Anthem stated without sufficient evidence that the level of care billed was higher than the actual level of care provided. While it is not uncommon for health plans to review provider claims and determine whether they believe the claim should be adjusted based on bundling, downcoding, benefit limitations, and the like, it is unprecedented for a payer to simply stop payment to a physician group entirely because of a purported disagreement by the insurer over the code billed. Instead, insurers will usually pay emergency physicians what they unilaterally believe is appropriate, and our members can then decide whether to challenge that reimbursement through state law mechanisms or, if the insurance product in question is federally regulated, through the independent dispute resolution process established under the No Surprises Act.

This is well-established practice because the law requires insurers to make a good faith effort for payment of a complete claim. Anthem refused to pay millions of dollars in claims that were correctly coded and billed. In fact, one of the emergency physician groups involved was able to compare their own records for such denied cases with those of the hospital's, and found that the hospital was paid at a Level 5 – casting significant doubt on Anthem's assertion that the physician claims were fraudulently coded too high. The emergency care safety net will fail in short order if insurers refuse to make payments as required by law. Physician groups have already indicated that the lack of sufficient revenue makes it difficult to provide adequate staffing. Attracting and retaining the best emergency physicians to treat patients is our top priority. The Anthem actions were particularly egregious as they appeared to be targeted just at small emergency physician groups that staff only a single hospital – as small businesses, these groups are the least able to absorb delays or denials of payment, nor do they have the staffing resources to continue to appeal this through the insurer's labyrinthine appeals processes. Fortunately, after policymakers, the media, and others added to the chorus of concern, the pressure became impossible to ignore and Anthem ultimately dialed back its policy.

In 2024, Aetna instituted a new policy update to its Claim and Code Review Program for emergency services to "downcode" Level 4 and 5 codes, lowering the severity of physician and facility claims for emergency services for commercial, Medicare Advantage, and student health policies. The policy was set as a national policy, but its use was noticed in California. In the policy update, Aetna stated it would "review physician and facility claims for Emergency Room Services, and we'll evaluate the proper use of the Level 4 and 5 E&M [Evaluation and Management] coding" that physicians submit, and "may adjust your payment if the claim details don't support the level of service billed." Despite multiple requests by affected parties, Aetna refused to share the actual policy language itself, and the notice provided little to no detail on what Aetna believed constitutes proper use of the Level 4 and 5 codes.

As in the previous example, the prudent layperson standard prohibits the use of final diagnosis codes to determine payment or coverage. Among other flaws in the policy, what was additionally concerning was how the insurer could have used this policy to delay all Level 4 and 5 E&M code payments and further squeeze funding to the health care safety net. And once again, after efforts by ACEP, California ACEP, and the California Medical Association, Aetna eventually announced it would not continue this dangerous and misguided downcoding policy in California. While these specific tactics are no longer a threat to patients or physician practices in California, we remain concerned that they could be employed again in other states.

Prior Authorization Burdens and the Emergency Department Boarding Crisis

With respect to prior authorization processes, ACEP is deeply appreciative of legislators' efforts to curb burdensome prior authorization processes that only serve as barriers to timely, medically necessary care and contribute to growing levels of physician burnout. As you know, an April 2022 report by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) detailed how prior authorization in the Medicare Advantage (MA) program has harmed patients, with MA organizations delaying or denying care even though the care met Medicare coverage rules, requesting unnecessary documentation, and making manual review and system errors.[2] ACEP strongly supports the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514/S. 1816) to streamline and standardize prior

[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

authorization processes under the Medicare Advantage program, and we urge Congress to swiftly take up and pass this important legislation.

While prior authorization is prohibited when patients are experiencing medical emergencies, the process still has a significant downstream effect on patients and emergency physicians alike. Many emergency physicians have treated patients who were unable to receive timely services in other care locations due to prior authorizations denials who came to the ED specifically to receive those services (sometimes at the direction of their primary care physician or specialist). While this is clearly not the intended or appropriate reason for a patient to receive treatment in the ED, it reflects the fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols, leaving frustrated patients (and their providers) with no other options to receive medically necessary care, and further driving up the cost of care for all.

The downstream effects of prior authorization often manifest in the ED by exacerbating the ongoing ED patient boarding crisis.[3] Many health plans require prior authorization before a patient can be transferred from the hospital to a post-acute care facility, like a skilled nursing facility (SNF). The American Hospital Association (AHA) has also noted these concerns – in their response to the Contract Year 2023 MA proposed rule, the AHA noted how prior authorization was affecting hospital capacity, stating that the use of prior authorization is "especially problematic when general acute-care hospital beds have been filled to capacity" and continued use of the process has also "resulted in unintended consequences for patients who were then forced to stay in acute care settings while waiting for health plan administrative process to authorize the next steps of care." ACEP believes that MA plans should be prohibited from requiring prior authorization in order to transfer patients to post-acute facilities, and that this policy could be one possible short-term solution that could help the boarding crisis.

Insurer Efforts to Undermine the Patient Protections of the No Surprises Act

ACEP also urges Congress to address relentless insurer efforts to sidestep and undermine the No Surprises Act. As you well know, this important law established critical safeguards to protect patients from out-of-network billing disputes between health care providers and insurers, while not tilting the carefully-crafted independent dispute resolution (IDR) process in favor of either party. This law was intended to promote open negotiation, and we strongly agree that this should be the first line of defense in out-of-network billing disputes. Emergency physicians remain committed to the principles of the NSA's promise to take the patients out of the middle, and like Congress, continue to believe that the IDR process should be the option of last resort for billing disputes. Unfortunately, insurers are largely refusing to engage in the open negotiation process whatsoever, often doing nothing but delaying payment for claims they know will be unsuccessful in IDR later.

In the time since this landmark federal protection was signed into law in 2020 as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), insurers have flagrantly abused the flawed implementation of the law and have even exploited the regulations in attempts to strongarm physician groups into accepting drastic cuts to long-standing **in-network** contracts.[4] These actions began even before the No Surprises Act fully went into effect – in North Carolina in 2021, insurers sent letters threatening to terminate agreements with in-network physicians by taking advantage of the interim final regulation (IFR) that had been issued. In many cases, groups who received these notices had longstanding contracts that not only had not increased at all, but in fact had actually significantly decreased due to factors like inflation and increased patient burden due to high deductibles without ability to pay. Some of these termination threats requested contract reductions from 20 to 40 percent, with threat of termination if the groups did not accept these massive cuts – with the letters explicitly citing the new IFR as rationale for taking such action.

One group of emergency physicians in North Carolina, serving 11 emergency departments in the state, including a HPSA-designated hospital, a children's hospital, and several rural locations, received a letter from Blue Cross Blue Shield of North Carolina in November 2021 threatening termination if it did not accept an immediate interim 20

[3] https://www.acep.org/administration/crowding--boarding
[4] https://www.acep.org/siteassets/new-pdfs/advocacy/acep--nccep-insurer-cuts-letter-to-nc-delegation---12092021.pdf

percent cut to its contracted rate. The letter specifically stated that Blue Cross would then require a new rate closer to the Qualifying Payment Amount (QPA), the new payment standard under the IFR, and that if no new agreement was reached, Blue Cross would terminate the contract and just pay the QPA moving forward. Similarly, this same group had been in-network with a stable contract with UnitedHealthcare since 2014 and was threatened with termination after nearly 8 years unless it agreed to a 40 percent rate cut. Another insurer with whom the group had been in network with since 2011 also requested to renegotiate the contract with greatly reduced rates.

Emergency physician Seth Bleier, MD, FACEP, testified before the House Committee on Ways and Means in a hearing entitled, "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections," calling out insurer abuses of the NSA and sharing how smaller physician practices have been virtually shut out of the IDR process, subjected to significant cuts to longstanding contracts, or are simply not paid at all even when they are successful in IDR.

Insurer complaints about the IDR process have been disingenuous at best. In practice, insurers continue to not provide open lines of communication, do not engage or often even respond at all throughout the open negotiation or IDR process, intentionally obfuscate information physicians need to determine eligibility for claims, and often refuse to take up their opportunities to participate in the selection of IDR entities in disputes. Instead, they wait until **after** IDR entities have made a payment determination to raise objections – or they simply refuse to abide by the determination or pay anything at all. As physicians, we frequently are not provided with all the information we need to indicate if a claim is eligible for the federal IDR process or not. Insurers continue to withhold information physicians need to determine eligibility for claims or change plan types in the middle of the process (often in violation of statutory requirements to disclose specific information) and then accuse physicians of "flooding" the IDR process with ineligible claims when they are the ones with the information needed to determine eligibility. We are hopeful that the proposed IDR operations rule will be finalized in the near future, which ideally will resolve many of these longstanding frustrations with the process, and we echo the comments recently made by Senators Bill Cassidy, MD, and Maggie Hassan, urging the Trump administration to issue the final IDR operations rule and pursue additional changes to identify and remove ineligible disputes in a swift and efficient manner.[5]

The insurance industry has also alleged that physicians and providers are abusing the IDR process, knowingly flooding the system with claims that are ineligible and submitting offers much higher than the QPA. Recent data shows that providers are increasingly successful in IDR disputes, winning nearly 90 percent of the time. Insurers and some observers have suggested that this lopsided outcome is the result of a broken system or abusive behavior by providers. However, if an independent dispute resolution entity is required to determine which of two offers is the most appropriate and justifiable, and these entities are choosing in favor of providers in 90 percent of cases, the question should not be why are providers winning so much, but instead just how unserious are the offers that insurers continue to submit? The NSA was intended to change behaviors and bring prices in line more fairly so that, ideally, the need for the IDR process at all would eventually be obviated, or at least be utilized far less frequently.

More concerningly, insurer abuse of the NSA is not limited solely at physicians and providers – many practices have reported that health plans have at times increased the patient cost-sharing amounts *after* an IDR determination, undermining the fundamental cornerstone goal of the NSA in removing patients from the middle of billing disputes. While subsequent legal decisions have helped bring NSA regulations closer to statute and congressional intent, there is still work to be done to fully implement the law appropriately as Congress truly intended.

In 2025, ACEP and the Emergency Department Practice Management Association (EDPMA) noted in a joint letter[6] to the Deputy Administrator & Director of the Center for Consumer Information and Insurance Oversight (CCIIO) the growing trend of health plans and insurers subverting and abusing the IDR process by submitting final offers of $0.00 to avoid paying emergency clinicians for their services.

[5] https://www.help.senate.gov/letter-to-secretary-kennedy-on-nsa-implementation_01162026pdf
[6] https://www.acep.org/siteassets/new-pdfs/advocacy/acep-and-edpma-letter-on-zero-pay-offers.pdf

Following an out-of-network patient visit and subsequent claim submission, the NSA requires plans and issuers to either 1) make an initial payment to the billing physician or group, or, 2) deny the submitted claim. The law's implementing regulations specify that this initial payment amount "should be an amount that the plan or issuer **reasonably intends to be payment in full** based on the relevant facts and circumstances and as required under the terms of the plan or coverage"[7] (emphasis added). If the physician disagrees with this initial payment, they can dispute it via the 30-day open negotiation period. Should there be no resolution during that period, either party has the option to initiate IDR.

An offer of $0.00 by the insurer indicates that the plan believes the service provided by the physician had no monetary value; yet their initial payment of any amount higher than that (rather than an outright claim denial) signifies the plan had a good faith belief that the claim was indeed valid and reimbursable. In other words, a final offer of $0.00 contradicts entirely the insurer making an initial payment instead of denying the claim in the first step of the out-of-network billing process.

By failing to deny the claim early in the process, insurers are blocking physicians from utilizing the normal and customary appeals process that follows a denial and does not increase costs for either party. Additionally, the plan or issuer already made a payment on the claim, suggesting the plan or issuer believed at the time of the payment that there is at least some value to the service rendered. Sending a final offer of $0.00 in IDR – which will require a refund from the clinician to the plan or issuer should that offer be accepted by the IDR entity (IDRE)[8] – and results in the plan being unjustly enriched by not paying anything for a service rendered. Nearly all commercial insurance plans provide coverage for emergency services regardless of contract status. To require "coverage" but not "payment" for that coverage belies that some portion of the insurance premium includes the costs for emergency services. This action also violates the Prudent Layperson Standard, as the plan's $0.00 offer essentially asks the IDRE to determine medical necessity – if medical necessity was in question, this should have been an initial claim denial.

Beyond these, insurers are employing other new tactics to undermine the NSA. On January 1, 2026, Anthem implemented a new policy in eleven states (Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, and Wisconsin) penalizing hospitals when care is delivered by an out-of-network physician. This policy states that facilities will receive a 10 percent payment cut on claims involving an out-of-network physician, and that Anthem may potentially terminate hospitals from its networks for continued use of out-of-network clinicians. As noted in a joint letter to Anthem (Elevance) leadership from ACEP, the American Society of Anesthesiologists (ASA), and the American College of Radiology (ACR), this policy is deeply flawed and operationally unworkable, as it "effectively shifts Elevance's network adequacy obligations onto facilities, holding them financially liable for the contracting status of independent physician groups – an area over which they have no control or infrastructure to manage." The letter also noted how "expecting facilities to monitor and enforce payer contracts across dozens of independent entities and multiple commercial plans is not only impractical but raises serious legal and ethical concerns." This policy is a deliberate effort to circumvent the NSA, which already provides a mechanism for resolving out-of-network payment issues.

At minimum, ACEP urges Congress to consider the bipartisan "No Surprises Act Enforcement Act," (H.R. 4710/S. 2420). This straightforward legislation reinforces the NSA by closing enforcement gaps through increased penalties for non-compliance of statutory payment deadlines, providing parity between penalties imposed against parties non-compliant with statutory patient protection provisions, and increasing transparency in reporting requirements. We further ask Congress to continue its critical oversight role to ensure proper ongoing implementation of the law per clear congressional intent, and to address the myriad examples of bad insurer practices that harm patients and their health care providers.

---

[7] Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,900-01 (July 13, 2021)

[8] Per IDR Guidance for Disputing Parties, the "provider…will be liable to the plan when the offer selected by the certified IDR entity is less than the sum of the plan's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee."

Thank you once again for this important joint effort to examine the role of insurers in the affordability of health care as we all work to improve access to the affordable, high-quality care our patients need and deserve. Should you have any questions or need any additional information, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

L. Anthony Cirillo, MD, FACEP
President, American College of Emergency Physicians