Emergency Physicians' Priorities: Holding Insurers Accountable & Protecting Patient Access

Who we are
Emergency physicians provide 24/7 care to all patients, regardless of insurance status or ability to pay. Under federal law, the Emergency Medical Treatment and Labor Act (EMTALA), emergency departments must evaluate and stabilize every patient who seeks emergency care.

Key Concern: Insurer Practices Are Harming Patients

Recent congressional hearings in the House Energy and Commerce Committee and House Ways and Means Committee highlighted insurer behaviors that are directly undermining patient access to emergency care.

Documented Examples of Abusive Insurer Practices

Emergency physicians routinely experience:

- **No Surprises Act violations by insurers**, including:
    - Refusing to meaningfully participate in the open negotiation period and Independent Dispute Resolution (IDR) process
    - Delaying or failing to pay IDR awards for months—or not paying at all—after final decisions
    - Forcing physicians to repeatedly resubmit documentation already provided
- **Systematic downcoding of emergency care**, such as:
    - Reclassifying high-acuity ED visits as low-level services despite clear documentation
    - Applying non–emergency billing codes to visits involving chest pain, stroke symptoms, sepsis, or trauma
    - Using automated claims edits that ignore physician notes and clinical complexity
- **Improper denials of emergency services**, including:
    - Denying claims based on final diagnosis rather than the patient's presenting symptoms
    - Retroactively denying coverage by second-guessing whether an emergency "really existed," in violation of the prudent layperson standard (PLS) enacted more than 20 years ago to protect patients
- **Weaponization of administrative processes**, including:
    - Repeated requests for unnecessary records to delay payment
    - Silent denials without explanation or appeal pathways

    - Shifting payment responsibility to patients despite federal protections

These practices accelerate physician burnout, harm patients, and threaten access to emergency care—especially in rural and underserved communities.

Insurers Are Not the Cost-Control Solution

Despite insurer claims during recent hearings, Members of Congress from both parties raised concerns about:

- **Insurer consolidation and market dominance**, limiting competition
- **High insurer profits and executive compensation**, even as payments to frontline clinicians' decline
- **Vertical integration** between insurers, pharmacy benefit managers (PBMs), and other intermediaries
- **Aggressive prior authorization practices**, particularly in Medicare Advantage

These practices not only create burdens, limit options, and raise costs for patients, but accelerate the growing rates of stress, dissatisfaction, and burnout among physicians.

Medicare Advantage: A Growing Problem for Seniors

- Federal oversight agencies have found widespread inappropriate denials of care and payment in Medicare Advantage plans.[1]
- Examples include:
    - Prior authorization denials for services that would be covered under traditional Medicare
    - Narrow or "ghost" networks that falsely list emergency and specialty providers as in-network
    - Delays that force seniors to seek emergency care when outpatient care is denied or unavailable
    - Delays in transfer authorizations by insurers, exacerbating the hospital ED "boarding" crisis

Robust networks and transparent plan designs, without unnecessary administrative burdens, improve access and reduce unnecessary ED visits.

What Emergency Physicians Are Asking Congress to Do

- Enforce the NSA and encourage the Administration to release the IDR operations rule to hold insurers accountable for noncompliance and ensure the IDR process works more efficiently and effectively
- Require timely, full payment of IDR awards
- Consider and pass the bipartisan "No Surprises Act Enforcement Act" (H.R. 4710/S.2420) to close enforcement gaps
- Swiftly take up and pass the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514/S.1816) to streamline and standardize prior authorization in the Medicare Advantage program
- Protect funding through the appropriations process that sustains emergency departments, physician workforce, trauma systems, and patient access to care

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Bottom line:
Emergency physicians are not discretionary providers; we are required by law to treat every patient, every day. A report on emergency care issued by RAND in April of 2025 found that across all payers, 20 percent of emergency physician payments go unpaid – **representing $5.9 billion in annual losses**. Declining physician reimbursement by payers and continued non-payment only serve to jeopardize the health care safety net for patients in need of lifesaving emergency care.

Emergency physicians put patients first. Congress must ensure insurers follow the law and stop practices that delay care, deny coverage, and threaten access to emergency services.

Selected Federal Sources

1. **HHS Office of Inspector General (OIG)** *Medicare Advantage Organizations Denied Prior Authorization Requests That Met Medicare Coverage Rules* (2022).
2. **U.S. Government Accountability Office (GAO)** — *Medicare Advantage: CMS Should Improve Oversight of Prior Authorization* (2022–2023).
3. **Centers for Medicare & Medicaid Services (CMS)** — *No Surprises Act Independent Dispute Resolution Operations Reports* (2023–2024), documenting payment delays, backlogs, and compliance concerns.