American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 18, 2026

The Honorable Morgan Griffith
Chair
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Committee on Energy and Commerce
2323 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for the opportunity to share our comments on today's hearing, entitled, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape." We appreciate the committee's continued efforts to identify and address the factors contributing to surging health care costs, including the growing financial strain on physician practices that hinders access to care for our patients.

As you well know, emergency physicians serve on the frontline of the health care system and provide care under circumstances and laws that are unique among other physician and provider specialties. Both by oath and under the federal Emergency Medical Treatment and Labor Act (EMTALA), emergency physicians provide lifesaving emergency care to every patient regardless of their insurance status or ability to pay. As a result, we provide more uncompensated care than any other physicians or providers, and combined with growing financial and operational pressures, the health care safety net is under increasing strain.

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 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 (ED), 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.

Declining payments for emergency services further compound the financial pressure on emergency medicine. From 2018-2022, commercial insurance payments to emergency

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

physicians dropped 10.9 percent in-network and 47.7 percent out-of-network. Medicare and Medicaid payments per visit also dropped 3.8 percent during the same period. Together, Medicare and Medicaid account for more than 65 percent of ED visits (33.6 percent and 32 percent, respectively), so the cumulative impact of continued reimbursement cuts in federal programs alone has a disproportionate effect on emergency medicine. Additionally, bad insurer practices such as those detailed in ACEP's statement for the record for the recent congressional hearings with insurance company executives, as well as growing health care consolidation, not only add financial burdens but are also major sources of stress and burnout for emergency physicians.

Improving the Medicare Physician Payment System

ACEP strongly supports efforts to stabilize the Medicare physician payment system, including the need for a permanent inflationary update based upon the Medicare Economic Index (MEI), such as the bipartisan "Strengthening Medicare for Patients and Providers Act" led by Representatives Raul Ruiz, MD (D-CA) and Gus Bilirakis (R-FL), improvements and updates to the Physician Fee Schedule's (PFS) budget neutrality rules to mitigate year-to-year fluctuations in the conversion factor, and necessary improvements to the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to assist in the transition toward more value-based payment models. We also ask Congress to act before the end of the year to prevent any potential cut that may result from possible negative budget neutrality adjustments in the upcoming calendar year (CY) 2027 PFS rule and the expiration of temporary relief provided by Congress through the end of 2026.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net, but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and we support efforts to provide greater stability and certainty in the Medicare system.

While the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and the repeal of the flawed Sustainable Growth Rate (SGR) policy helped address some shorter-term physician payment issues, according to the 2022 Medicare Trustees Report there are "…important long-range concerns that will almost certainly need to be addressed by future legislation." The Trustees noted that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.

We believe that with improvements, developed through collaboration with Congress, regulators, and stakeholders as originally intended, MACRA can be significantly more effective in facilitating the transition to value based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and iteration to help us attain a sustainable payment system that truly incentivizes high-quality, cost-effective care and to ensure that we do not expend our time and resources in vain trying to achieve that ultimate goal. To this end, ACEP responded to a recent bipartisan request for information from the House GOP Doctors Caucus and Congressional Doctors Caucus, detailing some of our proposals on legislative reforms needed to improve, modernize, and stabilize the Medicare physician payment system. We look forward to working together with Congress to identify substantive long-term reforms, and urge you to hold hearings and convene stakeholder roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Addressing the Emergency Department Boarding Crisis

Patient "boarding" occurs when a patient continues to occupy an ED bed even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to psychiatric, skilled nursing, or other specialty facility. A direct result of hospital system overload as our health care system becomes increasingly

strained, these patients must stay in the ED for days or even weeks on end waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely and quality care to all patients, forcing other newly arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even twelve hours rapidly becoming a new norm, and patients even dying during these waits as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities that have little to no available beds, or, waiting to simply return to their nursing home. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician. These conditions not only worsen patient experiences and outcomes, but they add significant and unnecessary costs throughout the continuum of care.

To illustrate the stark reality of this crisis, ACEP asked its members to share examples of the life-threatening impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."*
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> – anonymous emergency physician

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and "load balancing" plans for boarding/crowding scenarios, and fewer regulatory or other "red tape" burdens that delay necessary care. **ACEP strongly supports the bipartisan H.R. 2936, the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act," led by Representatives John Joyce, M.D. (R-PA) and Debbie Dingell (D-MI)**, that will help ensure more efficient use of health care resources, relieve pressures on strained emergency departments, and most importantly, improve patient experiences and outcomes by expanding real-time hospital bed tracking systems using existing federal resources, pilot innovative care transition models for older adults and patients with acute psychiatric needs, and direct the Government Accountability Office (GAO) to study best practices in hospital capacity tracking and its impact on boarding and emergency care delays.

Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP continues working to develop a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. We strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short- and long-term solutions to this public health 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.[2] 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 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

[2] https://www.acep.org/siteassets/new-pdfs/advocacy/acep--nccep-insurer-cuts-letter-to-nc-delegation---12092021.pdf

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.[3]

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[4] 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.

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"[5] (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)[6] – 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

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[3] https://www.help.senate.gov/letter-to-secretary-kennedy-on-nsa-implementation_01162026pdf

[4] https://www.acep.org/siteassets/new-pdfs/advocacy/acep-and-edpma-letter-on-zero-pay-offers.pdf

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

[6] 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."

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.

Once again, thank you for your continued attention to the issue of health care affordability and for the opportunity to share our comments with you. 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,

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