

Independent Emergency Physicians Consortium



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WELCOME



Welcome to the September 2026 issue.

This month we are focused on two issues that shape how independent groups get paid and how we practice. On the reimbursement side, the conversation around how the No Surprises Act gets enforced is active and evolving, and we are following it closely. On the practice side, California's 2027 MICRA changes are coming into view, and there is value in reviewing what they mean for your group now, while there is time to plan.

We have also included a look at a new CMS quality measure heading for emergency departments, so you can get familiar with how this will be scored well ahead of when it takes effect.

We close with the details for our September 28th meeting and hope you will join us. Thank you, as always, for the care you provide on the front lines and for being part of the IEPC community.

All the best,
Kavitha Weaver

REGULATORY UPDATE

ACEP Challenges Health Affairs IDR Analysis

ACEP has rebutted an August Health Affairs analysis attributing more than \$22.4 billion in excess No Surprises Act costs to the IDR process, calling the estimate methodologically unsound. Its core objection: the analysis anchors to insurer-calculated QPAs, a methodology the Fifth Circuit has already struck down as unlawful, and relies on federal dispute data ACEP says is significantly compromised by error, including an estimated \$6 billion in duplicative or mis-entered awards. Physicians still prevail in roughly 85% of arbitrated cases; ACEP argues the analysis sidesteps the insurer conduct behind that record, from no-offer responses to initial offers of \$0-\$1 in over a third of cases.

ACEP's position is that outlier awards call for targeted oversight, not a dismantling of IDR based on insurer-preferred data.

Read ACEP's full statement:

[Flawed Health Affairs Analysis Relies on Unlawful QPA Data](#)

Federal Advocacy Priorities

For the federal advocacy picture on surprise billing, this episode of ACEP Frontline features Dr. Ryan Stanton, ACEP's President-Elect and our featured speaker on **September 28th**, in conversation with July IEPC speaker Ryan McBride, ACEP's Senior Director of Federal Government Affairs.

Together cover the current state of NSA enforcement and IDR, and where the debate goes next in Congress.



Listen here (24 min):

[ACEP Advocacy Priorities with Ryan McBride](#)

Understanding CMS's ECAT Measure

CMS's Emergency Care Access & Timeliness (ECAT) measure enters voluntary reporting under the Hospital Outpatient Quality Reporting program in CY2027. It does not work like the timing metrics we have benchmarked for years, and it is worth reviewing how it is scored before it takes effect.

ECAT is a single composite failure rate. A visit counts against you if it trips any one of four gaps: time to treatment room over 60 minutes, left-without-being-seen, boarding over 240 minutes from decision-to-admit, or total ED length of stay over 480 minutes. Two features are notable: there is no clinical risk adjustment, and two of the four criteria are driven largely by inpatient and psychiatric bed capacity. EDBA notes that high-acuity, safety-net, academic, and high-boarding facilities should expect to score less favorably on ECAT than they do on the median-based timing measures we are used to.

EDBA is asking every member ED to complete its ECAT Data Collection Worksheet for CY2025 now, two years before the measure is reportable. Completing it early establishes a baseline while the stakes are zero, surfaces data-capture gaps before CMS does (most EDs cannot yet cleanly pull time-to-treatment-room or a durable decision-to-admit timestamp), and helps build the peer-comparison dataset EDBA plans to publish for members. Once your analytics team has the query built, the worksheet takes under an hour.

The worksheet and a plain-language definitions summary are posted at edbenchmarking.com, along with submission instructions. Technical questions on ECAT logic, value sets, or timestamps can also go directly to CMS through the eCQM Issue Tracker.

MICRA Reform - What ER Groups Need to Know

This piece was contributed by Prevail Insurance. For questions, contact Ben Borchers (ben@prevailims.com / 916.745.8801) or Devin Ekhardt (devin@prevailims.com / 916.745.8802)

The Original MICRA Law

MICRA was enacted in 1975 in order to create stability in California's healthcare industry and to help reduce medical malpractice insurance premiums. At the time, the high cost of premiums was considered a threat to the accessibility and the quality of healthcare in the state. The reform allowed for more predictable losses, resulting in decreased malpractice liability insurance premiums, and kept the medical service provider industry profitable, allowing for wide access to affordable care for patients. The original MICRA legislation made three changes to medical malpractice lawsuits in California:

- Imposed a \$250,000 cap on non-economic damages in medical malpractice actions.
- Set staggered limits on contingency fees for attorneys based on the amount recovered.
- Created several litigation rules for medical malpractice cases.

New MICRA Reform Law – What Has Changed

Over the past 50 years, the California plaintiffs' bar, consumer protection groups, victim advocates, and lobbyists have tried to pass legislative reform to either eliminate the MICRA-established cap entirely or raise it with built-in provisions for annual increases. After numerous ballot measures were defeated, proponents made progress in 2022 by advancing a November 2022 ballot measure that would have significantly altered MICRA by substantially raising the non-economic damages cap and eliminating many important protections. Lawmakers drafted Assembly Bill 35 (AB 35) as a compromise from both sides of the aisle to reform MICRA and it was signed into law by Governor Gavin Newsom in May of 2022. The new law went into effect January 1, 2023 and it increases the non-economic damages cap to \$350,000 for non-death cases and \$500,000 for wrongful death cases. Each year, there are incremental increases over a 10-year period until the cap reaches \$750,000 for non-death cases and \$1 million for wrongful death cases, after which a 2% annual inflationary adjustment will apply.

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Current and Future Caps

Case Type	Prior Cap	Current Cap 2026	Annual Increase	2033 Cap	Annual Increase Beyond 2033
Non-Death Cases	\$250,000	\$470,000	\$40,000	\$750,000	2% annual increase
Wrongful Death Cases	\$250,000	\$650,000	\$50,000	\$1,000,000	2% annual increase

Additionally, the bill has created three separate categories of caps for recovery:

- Physicians - one cap for all the physicians involved in the incident.
- Facilities - a second cap for the facility involved in the incident (i.e. hospital, surgery center, imaging center).
- Unaffiliated Physician and/or Unaffiliated Facility - a third cap for an unaffiliated physician and/or facility that causes an additional injury/death.

There are scenarios where a single plaintiff can utilize multiple caps to increase the size of the demand for non-economic damages. For example, a patient is treated at the emergency department, dies, and then the family sues both the emergency physician that treated the patient and the hospital where the care took place. Under the new law, the plaintiff can sue the emergency physician for \$650K and the hospital for \$650K. The combined total is \$1.3M and significantly increases the financial exposure of the overall lawsuit.

What Does This Mean for ER Groups and the Healthcare Industry?

The obvious concern from the perspective of ER groups, hospitals and healthcare providers is the potential for an increase in the frequency and severity of litigation. The healthcare industry is already facing many challenges that include a shortage in talent. This creates delays in care and overworked medical professionals, leading to an increased potential for misdiagnosis, mishaps, and other various medical malpractice concerns. An increase in the MICRA caps only compounds the problem in an already highly litigious legal environment. A higher average cost of claims will lead to increased malpractice insurance rates, meaning a higher cost of medical practice in California. This in turn could lead to increased costs and the reduction of access to affordable healthcare.

There is also a change in the attorney fee structure which allows for higher contingency fees after the filing of a civil complaint or arbitration demand.

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These changes also dramatically increase total available attorney's fees as a percentage of the recovery available to the injured patient. It is hard to see how the core constituency- the injured patient-“wins” with these new changes related to fees.

Historically the malpractice insurance community hasn't looked favorably upon ER groups due to the lack of a doctor-patient relationship, the complexity of patients that come through emergency departments, and the propensity of high-cost claims that pledge emergency medicine. As such, insurance companies have been very picky when offering coverage to ER groups and haven't had a strong long-term commitment to emergency medicine generally speaking. MICRA Reform is making this situation worse and most carriers are targeting ER groups as a specialty to keep an eye on and/or that need pricing adjustments.

How Will MICRA Reform Affect the Malpractice Insurance Market and ER Groups?

Rates & Premiums

The insurance marketplace has clearly communicated that changes are coming and premiums will increase. We anticipate a gradual adjustment to rates over time before the full effect of AB 35 begins to affect litigation—both cost and settlements/verdict amounts—and eventually malpractice insurance rates and healthcare costs. However, the reform creates uncertainty, which typically leads to a hard market.

In the short term, most carriers are saying that rates will not change in 2027. The California Department of Insurance (DOI) won't let admitted carriers make changes to base rates without seeking prior approval first. This process will take time and all the admitted carriers don't want to go through the arduous process until it is absolutely necessary.

However, insurance companies can make adjustments to group-size pricing and discretionary discounts whenever they would like. Most ER groups have special pricing such that the rates and premiums are based on a per-visit basis. These rates have been discounted over the years to make the overall premiums attractive. Due to the effects of MICRA Reform and the higher caps, ER groups may face higher rates and premiums at renewal and well before base rate increases are approved by the DOI.

Furthermore, insurance companies that do business in California on a non-admitted/authorized basis can change their rates now and without approval from the DOI. These companies have been rolling out premium increases in 2026 and not waiting around to see what happens.

Limits

Historically, ER groups have purchased limits of \$1M per occurrence, with a \$3M annual aggregate. While the definition of medical negligence has not changed, increased caps could drive an increase in the number and severity of claims, which would erode these limits at a faster rate. In future limit-setting decisions, physicians and hospitals must consider that increased primary limits or the purchase of excess limits can make physicians and facilities a target for increased litigation. From a long-term perspective, if higher limits become standard, this could create a capacity strain on the market and even lead to the exit of medical malpractice insurers from California over time. Furthermore, as the caps on non-economic damages get higher and higher, there becomes very little limit left to cover the economic damages of a lawsuit. As this becomes increasingly obvious, the hospital community will begin forcing ER groups and other hospital-based medical groups to increase their limits to \$2M per claim and \$4M annually. They will likely implement this during contract negotiations or overhaul the medical staff by-laws such that the higher limits are required in order to have hospital privileges. As a rule of thumb, the higher limits of \$2M/\$4M are approximately 22% more than \$1M/\$3M.

What Proactive Steps Can ER Groups Take Now?

- Discuss MICRA Reform (AB 35) with your broker, your claims reps, your insurance carrier and defense attorneys. Understanding your carrier's expected impacts of MICRA Reform on your risk profile and insurance premiums is critical. Clearly communicate the MICRA Reform changes with your staff and practice administrators.
- Review your insurance carrier's panel of attorneys and establish a strong working relationship with your defense team. Discuss defense best practices like proper documentation and use of informed consent and/or informed refusal forms.
- Perform a comprehensive review of your medical malpractice program. Start by evaluating your program structure—including limits, retentions, and terms and conditions—then conduct a risk transfer analysis and continue to monitor rates.
- Most importantly, review and update your risk management policies and procedures for loss prevention and mitigation. Work with your broker and carrier for any risk management needs to identify key loss drivers and address any shortcomings with training for your staff.
- With the passing of MICRA Reform, the landscape for medical malpractice insurance has changed. ER groups should anticipate new challenges in the placement of their malpractice insurance programs over time.

2026 IEPC SPEAKER SERIES



2026 IEPC Speaker Series *Free to All Friends of IEPC*

Dr. Ryan Stanton

A Vision for the Future: Stepping in as ACEP President

**Monday, September 28th, 2026
9:00 AM - 9:30 AM PDT**

Membership in IEPC is not required to attend. Advance registration for the meeting is required. After registering, you will receive a confirmation email with the information on how to join the call!

Visit www.IEPC.org for more information and to register!

Join Us: September Speaker Series:

We are honored to welcome Dr. Ryan Stanton, ACEP's President-Elect to our September speaker series. Dr. Stanton will share ACEP's national priorities and what they mean for independent groups practicing here in California.

Future Speakers:

October 26: Ed Gaines, VP of Regulatory Affairs at Zotec Partners

November 23: Dr. Andrew Selesnick, JD

Keep an eye on your email for more details!