Cassidy Seeks Common Ground on Surprise Billing Before His Exit

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Sen. Bill Cassidy wants to fix the No Surprises Act, which has led to payment disputes between insurers and providers, and is considering legislation to address the issue.

- A particular concern is ineligible claims being litigated in the dispute resolution process, with stakeholders citing this as a shared concern that needs to be addressed.
- The issue of ineligible claims is being discussed, with some arguing that claims should be removed from the process if they do not meet certain criteria, and others pushing for more transparency around eligibility.

A veteran health senator wants to fix a law designed to protect patients from surprise bills that has mired insurers and providers in payment disputes — and he might be making some headway.

Sen. Bill Cassidy (R-La.), the chair of the Senate Health, Education, Labor and Pensions Committee, **held round tables last month** to hear about the issues plaguing implementation of the No Surprises Act.

“Believe it or not, there’s common ground there,” he said. He said he would like to put out legislation before he leaves Congress.

A particular issue has emerged among stakeholders as a shared concern: ineligible claims being litigated in the dispute resolution process and clogging up the works.

Groups familiar with discussions, and who spoke anonymously to comment on behind-the-scenes private conversations, said the issue of ineligible claims was talked about at these closed-door meetings in the Senate. But there’s a short amount of time left on the legislative calendar to act.

Signed in 2020, the No Surprises Act was passed to protect patients from receiving surprise bills when they are treated by providers outside of their insurers' network, such as an unexpected visit to the emergency room. The statute also set up an arbitration process to determine payment between insurers and healthcare providers if they cannot agree on an amount.

Therein lies the problem, with **insurers and healthcare providers pointing fingers** at each other over who is causing costs to spiral out of control. Insurers say providers are flooding the system with claims, while healthcare providers argue insurers are not paying up in a timely manner, if at all.

"Congress has a responsibility to strengthen the No Surprises Act and restore program integrity by preventing ineligible claims and ensuring timely payment to physicians," said Senate HELP spokesperson Stephen Lewerenz, adding that Cassidy is "working on bipartisan legislative solutions that can pass Congress and be signed into law before January."

Ineligible Claims Become Focus

Claims for medical services could be found ineligible for the dispute resolution process for multiple reasons, including if the parties involved didn't follow timelines and didn't complete open negotiations. A 2025 Congressional Research Service **report** found that about one-fifth of closed disputes in 2024 were ineligible.

"There are statutory criteria on what makes it into this process, and many, many times, those guardrails are not followed and result in these kind of exorbitant payments," said David Merritt, senior vice president of external affairs at the Blue Cross Blue Shield Association, which backs improving the process to remove those ineligible claims.

"Working with providers to clean up the process so that only those cases that should be heard is a great place to start," said Merritt.

Physicians have also shared concerns around ineligible claims. Several provider groups, including the American Medical Association, sent a **letter** to administration officials in April arguing health plans were undermining the law. One of their concerns outlined included ineligible claims making their way into the process.

“Eligibility is often challenging for physicians to determine, including determining the appropriate regulator,” they wrote. The physicians groups want more transparency around eligibility of a claim.

The administration is attempting to work on the issue. The Centers for Medicare & Medicaid Services **finalized a rule in May requiring health plans to use certain systemic codes** to indicate if any claims or services rendered are eligible for the federal dispute process.

Some Push Back on Changes

Senior vice president of health policy at Radiology Partners Richard Heller acknowledged insurers’ concerns about ineligible claims, and suggested letting the CMS final rule take effect.

“Don’t make fundamental changes in the law until you get the chance for the law to run at steady state,” he said.

Radiology Partners was one of four organizations making up 70% of dispute resolution filings in 2023, according to a **Georgetown University analysis**. Heller pushed back against the idea that providers used the dispute process as a “profit-making engine.”

“It’s costly, it’s lengthy, and it’s unreliable,” Heller said. “Meaning, even if you win you might not get paid.”

A bill from Rep. Greg Murphy (R-N.C.), a urological surgeon, aims to get at that problem. The bipartisan No Surprises Enforcement Act (H.R. 4710) adds penalties for insurers who are late with payments to physicians or fail to pay at all.

Murphy said in September that the House Ways and Means Committee was looking at addressing the issues within the arbitration process and could iterate on his legislation.

“The whole purpose of the No Surprises Act was to take the patient out of the situation and bring insurers and providers together so that they have reasonable rates,” said Murphy. “What I’m trying to do is rule out the bad actors on both sides, so we can actually get back to a system to do what it was supposed to do.”

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