NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES
PROPOSED

SECOND AMENDMENT TO 23 NYCRR 400
INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES AND SURPRISE BILLS

I, Kaitlin Asrow, Acting Superintendent of Financial Services, pursuant to the authority granted by Sections 202 and 302 and Article 6 of the Financial Services Law, Section 301 of the Insurance Law, and Part BB of Chapter 57 of the Laws of 2026, do hereby promulgate the following Second Amendment to Part 400 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York, to take effect on August 26, 2026 and apply to disputes submitted on and after that date, to read as follows:

(NEW MATTER UNDERSCORED; DELETED MATTER IN BRACKETS)

A new subdivision (d) is added to section 400.1 to read as follows:

(d) The amendments made by the second amendment to this Part shall take effect on August 26, 2026, and apply to disputes submitted on or after that date.

Paragraphs (5), (8), and (10)-(13) of subdivision (c) and paragraphs (5), (6), (11)-(13) of subdivision (d) of section 400.7 are amended as follows:

(c) A health care plan shall provide the following information:

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(5) except with regard to a health benefit plan operated pursuant to Civil Service Law article 11 where the dispute does not involve a physician described in Financial Services Law section 604(b)(5), at least three fees paid in the last 24 months by the health care plan to reimburse similarly qualified non-participating physicians, non-participating hospitals, or non-participating referred health care providers for the same services in the same region that reflect the final and full payment to the non-participating physician, non-participating hospital, or the non-participating referred health care provider, if available;

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(8) except with regard to a health benefit plan operated pursuant to Civil Service Law article 11 where the dispute does not involve a physician described in Financial Services Law section 604(b)(5), for a dispute involving a non-participating physician, the usual and customary cost for the service, when the benchmarking database contains the usual and customary cost for the service subject to the dispute;

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(10) the information set forth in Financial Services Law section 604(c), as applicable;

(11) any other information the health care plan deems relevant;

[(11)] (12) the patient's coverage type;

[(12)] (13) an attestation affirming that the information provided by the health care plan is true and accurate; and

[(13)] (14) any information requested by the IDRE.

(d) A non-participating physician, non-participating hospital, or non-participating referred health care provider shall provide the following information:

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(5) except with regard to a dispute involving a health benefit plan operated pursuant to Civil Service Law article 11 where the dispute does not involve a physician [other than as] described in Financial Services Law section 604(b)(5), at least three fees paid to the physician, hospital, or non-participating referred health care provider, in the last 24 months for the same services rendered by the physician, hospital, or non-participating referred health care provider to other patients in health care plans in which the physician, hospital, or non-participating referred health care provider is not participating that reflect the final and full payment to the non-participating physician, non-participating hospital, or the non-participating health care provider, if available;

(6) except with regard to a dispute involving a health benefit plan operated pursuant to Civil Service Law article 11 where the dispute does not involve a physician described in Financial Services Law section 604(b)(5), the physician's, hospital's, or non-participating referred health care provider's usual charge for comparable services rendered to other patients in health care plans in which the physician, hospital, or non-participating referred health care provider is not participating;

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(11) the information set forth in Financial Services Law section 604(c), as applicable;

(12) any other information the physician, hospital, or non-participating referred health care provider deems relevant;

[(12)] (13) an attestation affirming that the information provided by the physician, hospital, or non-participating referred health care provider is true and accurate; and

[(13)] (14) any information requested by the IDRE.

Section 400.8 is amended as follows:

(a) Within three business days of [receipt of] receiving an application submitted by a health care plan, non-participating physician, non-participating hospital, non-participating referred health care provider or [a] patient, an IDRE shall screen the application for any conflicts of interest in accordance with section 400.4 of this Part. If

the IDRE determines a conflict exists, the IDRE shall reject the application and return it to the superintendent within those three business days.

(b) If the IDRE determines that a conflict does not exist, the IDRE shall, within three business days of [receiving an application submitted by a health care plan, non-participating physician, non-participating hospital, or non-participating referred health care provider:

(1) screen the application for eligibility;

(2) contact the health care plan, physician, hospital, or non-participating referred health care provider if additional information is needed to determine eligibility of the request for dispute resolution and provide the health care plan, the physician, hospital, or non-participating referred health care provider three business days to submit the information and provide an explanation of where the information should be sent. If the information is not submitted, the IDRE shall make a second request and provide one business day to submit the information. If the information is not submitted, or if the application is not eligible, the IDRE shall promptly reject the application.

(c) Within three business days of a determination that the health care plan's, physician's, hospital's or non-participating referred health care provider's application is eligible, or within three business days of receipt of] receiving [the patient's] an application, including a patient application from the superintendent, [the IDRE shall send notification of the assignment to] notify the health care plan, physician, hospital, non-participating referred health care provider and, for a patient initiated application, [to the] patient, of the assignment of the application to the IDRE. The IDRE shall include in the notification:

(1) a request for information to determine the application's eligibility;

(2) a request for the information specified in subdivisions (c), (d) and (e) of section 400.7 of this Part;

[(2)] (3) a request for any additional information that may be available to support the [appeal] application;

[(3)] (4) an explanation of where the information should be sent;

[(4)] (5) a statement that all information must be submitted to the IDRE within [five] 15 business days of the notification;

[(5)] (6) a statement that [if a partial response or no response is received, the dispute will be decided] the IDRE will decide the dispute based on the available information if some but not all the requested information is received; [and

[(6)] (7) a statement that the IDRE [shall not] is not permitted to reconsider a dispute for which a determination has been made based upon its [receipt of] receiving additional information subsequent to such determination; and

(8) a request for the IDRE's full dispute resolution process fee, except with regard to an application submitted by a patient.

[(d)](c) If the [requested] information and process fee is not received by the IDRE within [five] 15 business days, the IDRE shall make a [determination based on the information available to the IDRE. If the requested information or additional information is received before the determination is rendered, the IDRE shall consider the information] second request to the non-responding party and provide five business days to submit the information and process fee to the IDRE.

(d) After the IDRE receives the requested information from the parties, the IDRE shall review the application and information received to determine whether it is eligible for independent dispute resolution, including by considering the criteria set forth in Financial Services Law section 604(c). If the IDRE does not have enough information to review the dispute or if the applicant (other than a patient) does not pay the IDRE's full dispute resolution process fee, then the IDRE shall determine that the application is not eligible for independent dispute resolution. The IDRE shall promptly reject any application that is not eligible for independent dispute resolution.

(e) If the health care plan, non-participating physician, non-participating hospital, non-participating referred health care provider, or, for a patient-initiated dispute, the physician, hospital, or patient, fails to provide all information requested by the IDRE within the timeframes specified by this section, the IDRE shall proceed with the review of the dispute if the IDRE determines that the IDRE has enough information to review the dispute.

(f)(1) If the health care plan fails to respond to the IDRE's request for information or to pay the IDRE's full dispute resolution process fee when the health care plan is not the applicant, the IDRE shall automatically decide the dispute in favor of the non-participating provider, non-participating hospital, or non-participating referred health care provider.

(2) If the non-participating provider, non-participating hospital, or non-participating referred health care provider fails to respond to the IDRE's request for information or to pay the IDRE's full dispute resolution process fee when the provider or hospital is not the applicant, the IDRE shall automatically decide the dispute in favor of the health care plan.

(3) For patient applications, if the physician or hospital fails to respond to the IDRE's request for information when the physician or hospital is not the applicant, the IDRE shall automatically decide the dispute in favor of the patient.

[(e)] (g) If the IDRE determines, in a case involving a health care plan, based on the health care plan's payment or best and final offer, if applicable, and the non-participating physician's or non-participating referred health care provider's fee, or the non-participating hospital's fee or best and final offer, as applicable, that a settlement between the health care plan and the non-participating physician, non-participating hospital, or non-participating referred health care provider is reasonably likely, or that both the health care plan's payment or best and final offer, if applicable, and the non-participating physician's or non-participating referred health care provider's fee, or the non-participating hospital's fee or best and final offer, as applicable, represent unreasonable extremes, the IDRE may direct both parties to attempt a good faith negotiation for settlement. The health care plan and the non-participating physician, non-participating hospital, or non-participating referred health care provider may be granted up to ten business days for this negotiation, which shall run concurrently with the [30] 45 business-day period for dispute resolution.

[(f)] (h) The IDRE shall have the dispute reviewed by a neutral and impartial reviewer with training and experience in health care billing, reimbursement, and usual and customary charges. All determinations shall be made in consultation with a neutral and impartial licensed reviewing physician in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute. To the extent practicable, the reviewing physician shall be licensed in this State.

[(g)] (i) An IDRE shall make a determination within [30] 45 business days of receiving [the request for the dispute resolution] all information necessary to review the dispute.

[(h)] (j) For disputes involving a health care plan, in determining a reasonable fee for the services rendered, an IDRE shall select either the health care plan's payment, or in cases involving a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, the health care plan's best and final offer, if applicable, or the non-participating physician's or non-participating referred health care provider's fee, or the non-participating hospital's fee, or, in cases involving a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, the non-participating hospital's best and final offer, as applicable. For disputes that do not involve a health care plan, the IDRE shall determine a reasonable fee.

[(i)] (k) An IDRE shall use the relevant conditions, [and] factors, and exclusions set forth in Financial Services Law section 604 when determining the reasonable fee and shall consider any other information submitted by the parties pursuant to subdivisions (c)[(10)](11), (d)[(11)](12), and (e)(7) of section 400.7 of this Part provided, however, that for disputes involving a heath benefit plan operated pursuant to Civil Service Law article 11, where the dispute does not involve a physician described in Financial Service Law section 604(b)(5), the IDRE shall only consider geozips or zip codes where the provider rendered the services.

[(j)] (l) An IDRE shall forward copies of the dispute resolution determination to the health care plan, physician, hospital, or non-participating referred health care provider, superintendent, and as applicable, patient, within two business days of rendering the determination. The notification shall include:

(1) the fee determined to be reasonable along with the reasons for the determination, including a discussion of the fee charged by the physician, hospital, or non-participating referred health care provider, or, as applicable, the non-participating hospital's best and final offer; the fee paid by the health care plan, or, in cases involving a non-participating hospital, the health care plan's best and final offer, if applicable; the usual and customary charge, [for disputes involving physician services] if applicable; an explanation of the factors in Financial Services Law section 604(b)(1)(B) that demonstrated that the health care plan's payment or non-participating provider's fee closest to the allowed benchmark was materially different from the appropriate payment for the health care service, if applicable; and other information provided;

(2) a statement attesting that no prohibited material affiliation existed with respect to the reviewer or reviewing physician;

(3) the biographies of the reviewer and the reviewing physician; and

(4) a request for payment [to the party that] to a patient if the patient does not prevail.

[(k)] (m) An IDRE shall not divulge to the health care plan, physician, hospital, non-participating referred health care provider, or patient the name of the reviewer or reviewing physician assigned to the dispute.

[(l)] (n) For each dispute resolution determination made by the IDRE, the IDRE shall certify that:

(1) the IDRE, the reviewer and the reviewing physician assigned to review the dispute followed appropriate procedures as specified in Financial Services Law article 6 and this Part;

(2) the reviewer and reviewing physician met the criteria for conducting the dispute pursuant to Financial Services Law article 6 and this Part; and

(3) for the reviewer and reviewing physician assigned to review the dispute, the IDRE has obtained a signed attestation affirming, under penalty of perjury, that no prohibited material affiliation exists with respect to the reviewer's or reviewing physician's participation in the review of the dispute pursuant to section 400.4(d) of this Part. The attestation shall be in such form as prescribed by the superintendent.

[(m)] (o) An IDRE shall not reconsider a dispute for which a determination has been made based upon receipt of additional information subsequent to the determination.

(p) Pursuant to Financial Services Law section 608(b), an IDRE shall not commingle payments for the dispute resolution process with any other funds held by the IDRE and shall hold all payments in a separate account.

Paragraph (4) of subdivision (a) of section 400.10 is amended as follows:

(4) For disputes that are rejected as ineligible or [due to] are resolved in favor of the requesting non-participating physician, non-participating hospital, non-participating referred health care provider or health care [plan's] plan pursuant to section 400.8(f) of this Part due to a failure to submit information or the IDRE's full dispute resolution process payment, an IDRE may charge an application processing fee, which shall be the responsibility of the [requesting] physician, hospital, health care provider or health care plan who or that is the requesting party if the dispute is rejected as ineligible or who or that is the party that failed to submit information or the IDRE's full dispute resolution process payment.

Subdivision (d) of section 400.10 is amended as follows:

(d)(1) [Any] With regard to a dispute involving a patient and a physician or hospital, payments due to an IDRE under this section shall be made to the IDRE within 30 calendar days from receipt of the IDRE's written determination and invoice.

(2) Pursuant to Financial Services Law section 608(b), with regard to a dispute involving non-participating physician, non-participating hospital, or non-participating referred health care provider and a health care plan, an IDRE shall issue a refund of the dispute resolution process payment to the prevailing party or, in the case of a settlement or split decision, the pro-rated amount to both parties, within 30 calendar days of rendering a determination on the dispute or to the applicant within 30 calendar days of rejecting the dispute as ineligible.