STATE OF NEW YORK
DEPARTMENT OF FINANCIAL SERVICES
23 NYCRR 400

INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES AND SURPRISE BILLS

I, Benjamin M. Lawsky, Superintendent of Financial Services, pursuant to the authority granted by Sections 202, 301, 302, and Article 6 of the Financial Services Law, Section 301 of the Insurance Law, and Part H of Chapter 60 of the Laws of 2014, do hereby promulgate a new Part 400 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect upon publication in the State Register, to read as follows:

(ALL MATERIAL IS NEW)

A new Part 400 is added to read as follows:

Section 400.0	Preamble.
Section 400.1	Applicability.
Section 400.2	Definitions.
Section 400.3	Independent dispute resolution entity (IDRE) certification requirements.
Section 400.4	Conflict of interest.
Section 400.5	Responsibilities of health care plans for disputes regarding emergency services and surprise bills.
Section 400.6	Responsibilities of physicians and health care providers for disputes regarding emergency services and surprise bills.
Section 400.7	Process to submit disputes regarding emergency services and surprise bills.
Section 400.8	Responsibilities of an IDRE.
Section 400.9	IDRE record retention and compliance.
Section 400.10	Payment for the independent dispute resolution.

Section 400.0 Preamble.

Part H of Chapter 60 of the Laws of 2014 provided new rights and obligations, effective March 31, 2015, concerning disputes involving bills by health care providers. Health care plans, physicians, and when applicable, other health care providers and patients, have the right to request a review by an IDRE to resolve a payment dispute regarding a bill for certain emergency services or surprise bills. This Part implements the requirements of Financial Services Law Article 6 by establishing a dispute resolution process and the standards for such process, including criteria and the process for certifying and selecting an IDRE.

Section 400.1 Applicability.

(a) This Part shall apply to health care services provided in this State on and after March 31, 2015.

(b) This Part shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the Workers'

Compensation Law and Insurance Law Article 51, and shall not preempt any such law. This Part shall not apply to emergency services subject to Financial Services Law section 602(b).

Section 400.2 Definitions.

As used in this Part:

(a) *Active practice* means actively treating persons in a state where the physician is licensed.

(b) *Affiliated* means controls, controlled by, or under common control.

(c) *Control* shall have the meaning ascribed by Insurance Law section 107(a)(16).

(d) *Dispute resolution process* means a process to resolve a dispute for a fee for emergency services or a surprise bill.

(e) *Emergency condition* means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

(2) serious impairment to such person's bodily functions;

(3) serious dysfunction of any bodily organ or part of such person;

(4) serious disfigurement of such person; or

(5) a condition described in 42 U.S.C. § 1395dd (Social Security Act section 1867(e)(1)(A)(i), (ii) or (iii)).

(f) *Emergency services* means, with respect to an emergency condition:

(1) a medical screening examination as required under 42 U.S.C. § 1395dd that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. § 1395dd to stabilize the patient.

(g) *Health care plan* means an insurer licensed to write accident and health insurance pursuant to Insurance Law Articles 41 and 42; a corporation organized pursuant to Insurance Law Article 43; a municipal cooperative health benefit plan certified pursuant to Insurance Law Article 47; a health maintenance organization certified pursuant to Public Health Law Article 44; or a student health plan established or maintained pursuant to Insurance Law section 1124.

(h) *Health care provider* means a health care professional who is appropriately licensed, registered or certified pursuant to Education Law Title 8, or comparably licensed, registered or certified by another state, or a facility that is licensed or certified pursuant to Public Health Law Articles 5, 28, 36, 44 or 47, or Mental Hygiene Law Articles 19, 31 or 32, or comparably licensed by another state.

(i) *Independent dispute resolution entity* or *IDRE* means an entity certified by the superintendent pursuant to section 400.3 of this Part.

(j) *Insured* means a patient covered under a policy or contract with a health care plan. A patient insured by an insurer other than a health care plan is not an insured for purposes of this Part.

(k) *Material familial affiliation* means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

(l) *Material financial affiliation* means any financial interest of more than five percent of total annual revenue or total annual income of an IDRE or officer, director, or managers thereof; or reviewer or reviewing physician employed or engaged thereby to conduct any independent dispute review in the dispute resolution process. The term *material financial affiliation* shall not include revenue received from a health care plan or physician by:

(1) an IDRE to conduct a dispute resolution pursuant to Financial Services Law Article 6; or

(2) a reviewing physician for health services rendered to patients in this State.

(m) *Material professional affiliation* means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the IDRE.

(n) *Non-participating* means not having a contract with a health care plan to provide health care services to an insured.

(o) *Non-participating referred health care provider* means a non-participating health care provider to which an insured was referred by a participating physician without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating referred health care provider and that the referral may result in costs not covered by the health care plan.

(p) *Participating* means having a contract with a health care plan to provide health care services to an insured.

(q) *Patient* means a person who receives health care services, including emergency services, in this State.

(r) *Physician* means an individual licensed to practice medicine pursuant to Education Law Article 131 or as provided under the law of the State where the individual practices medicine.

(s) *Reviewer* means a person with training and experience in health care billing, reimbursement, and usual and customary charges who renders a dispute resolution determination in consultation with a reviewing physician.

(t) *Reviewing physician* means a licensed physician in active practice in the same or similar specialty as the physician that provided the service that is subject to the dispute resolution process, who renders a dispute resolution determination in consultation with a reviewer.

(u) *Surprise bill* means a bill for health care services, other than emergency services, received by:

(1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;

(2) an insured for services rendered by a non-participating referred health care provider, where the services were referred by a participating physician to a non-participating referred health care provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating referred health care provider and that the referral may result in costs not covered by the health care plan. A referral to a non-participating referred health care provider occurs when:

(i) health care services are performed by a non-participating health care provider in the participating physician's office or practice during the course of the same visit;

(ii) the participating physician sends a specimen taken from the patient in the participating physician's office to a non-participating laboratory or pathologist; or

(iii) for any other health care services performed by a non-participating health care provider, when referrals are required under the insured's contract; or

(3) a patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not timely received all of the disclosures required pursuant to Public Health Law section 24.

(v) *Usual and customary cost* means the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent, which is not affiliated with a health care plan.

Section 400.3 Independent dispute resolution entity (IDRE) certification requirements.

(a) An entity applying to be an IDRE certified to perform reviews regarding bills for emergency services and surprise bills pursuant to Financial Services Law Article 6 shall submit to the superintendent:

(1) a description of the proposed IDRE's organizational structure and capability to operate a statewide IDRE, including:

(i) a certificate of incorporation, articles of organization and bylaws or operating agreement of the proposed IDRE and, as applicable, those of the proposed IDRE's holding company or parent company;

(ii) the proposed IDRE's organizational chart;

(iii) identification of management staff and a description of such management staff's responsibilities;

(iv) the name and credentials of a medical director appointed by the proposed IDRE, who is a physician in possession of a current and valid non-restricted license to practice medicine in New York;

(v) the names and biographies of all controlling employees, officers, and executives of the proposed IDRE; and information concerning the governing board of the proposed IDRE, including roles and responsibilities, identification of the board members and a description of their qualifications;

(2) a sworn statement, as described in section 400.4(b) of this Part, signed by the chief executive officer of the proposed IDRE regarding conflicts of interest;

(3) the names of all corporations and organizations that control, are controlled by, or under common control with the proposed IDRE, and the nature and extent of any such control;

(4) the proposed IDRE's policies and procedures governing all aspects of the dispute resolution process, including at a minimum:

(i) a description and a chart or diagram of the sequence of steps through which a dispute will move from receipt through notification to the health care plan, physician, superintendent, and provider, insured, or patient, if applicable, regarding the dispute determination;

(ii) procedures for ensuring that no prohibited material familial, financial or professional affiliation exists with respect to the reviewer and reviewing physician assigned to the dispute. The procedures shall include, for each reviewer and reviewing physician assigned to review a dispute, a requirement for a signed attestation affirming, under penalty of perjury, that no prohibited material familial, financial or professional affiliation exists with respect to the reviewer's or reviewing physician's participation in the review of the dispute;

(iii) procedures to ensure that the dispute is reviewed by a neutral and impartial reviewer with training and experience in healthcare billing, reimbursement, and usual and customary charges and determinations are 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, who is also, to the extent practicable, licensed in New York;

(iv) procedures for the reporting and review of reviewer's and reviewing physician's conflicts of interest and for assigning or reassigning a dispute resolution where a conflict or potential conflict is identified;

(v) procedures to ensure that reviews are conducted within the time frames specified in section 400.8 of this Part and any required notices are provided in a timely manner;

(vi) procedures to ensure the confidentiality of medical and treatment records and review materials; and

(vii) procedures to ensure adherence to the requirements of this Part by any contractor, subcontractor, agent or employee affiliated by contract or otherwise with the proposed IDRE;

(5) a description of the reviewer and reviewing physician network, including:

(i) an assessment of the proposed IDRE's ability to provide review services statewide;

(ii) a description of the qualifications of the reviewers and reviewing physicians retained to review payment disputes, including current and past employment history and practice affiliations, as applicable;

(iii) a description of the procedures employed to ensure that reviewers and reviewing physicians reviewing payment disputes are:

(a) appropriately licensed, registered or certified, if applicable;

(b) trained in the principles, procedures and standards of the proposed IDRE;

(c) knowledgeable about the health care service which is the subject of the payment dispute under review; and

(d) with respect to reviewers, trained and experienced in health care billing, reimbursement and usual and customary charges;

(iv) a description of the methods of recruiting and selecting neutral and impartial reviewers and reviewing physicians and matching such reviewers and reviewing physicians to specific cases;

(v) the number of reviewers and reviewing physicians retained by the proposed IDRE, and a description of the areas of expertise available from reviewing physicians and the types of cases reviewing physicians are qualified to review;

(vi) the proposed IDRE's quality assurance program, which shall include written descriptions, to be provided to all individuals involved in such program; the organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in payment dispute reviews performed by the reviewer and reviewing physician; and the maintenance of program standards pursuant to this subdivision; and

(vii) written procedures documenting that:

(a) appropriate personnel are reasonably accessible not less than 40 hours per week during normal business hours to discuss the dispute resolution process and to allow response to telephone requests;

(b) a response to an accepted or recorded message shall be made not less than one business day after the date on which the call was received; and

(viii) documentation of accreditation by a nationally recognized private accrediting organization, if accreditation is available;

(6) a list of its fees, which shall reflect the total amount that will be charged by the proposed IDRE for reviews, inclusive of indirect costs, administrative fees and incidental expenses, and a description of the methodology used to calculate the fees. The description shall include the pro-rated fee that will be charged when a good faith negotiation directed by the proposed IDRE results in a settlement between the health care plan and the non-participating physician or non-participating referred health care provider. The description shall also include an application processing fee when the dispute is determined by the proposed IDRE to be ineligible for review. The description shall provide a waiver of the fee for disputes submitted by patients when the fee would pose a financial hardship to the patient;

(7) a description of the proposed IDRE's ability to accept requests for reviews, provide requisite notifications, screen for material affiliations, respond to calls from the State and meet other requirements during normal business hours; and

(8) such other information as the superintendent may require.

(b) An IDRE may not charge any fee unless it has been filed with the superintendent and the superintendent has determined that the fee is reasonable.

Section 400.4 Conflict of interest.

(a) No proposed IDRE shall be qualified for certification as an IDRE if it owns or controls, is owned or controlled by, or is under common control with any of the following:

(1) any national, state or local illness, health benefit or public advocacy group;

(2) any national, state or local society or association of hospitals, physicians, or other providers of health care services; or

(3) any national, state or local association of health care plans.

(b) An IDRE shall submit a sworn statement, as described in section 400.3(a)(2) of this Part, setting forth that none of the control affiliations proscribed in subdivision (a) of this section apply to the IDRE, and that the IDRE, its medical director and each of its owners, officers, directors and managers, either:

(1) has no material familial, financial, or professional affiliation with any person or entity listed in subparagraphs (i) – (vi) of paragraph (2) of this subdivision; or

(2) provides a list of those material familial, financial and professional affiliations, each of which may, upon certification, result in a prohibited conflict of interest in connection with a dispute because of such affiliation with:

(i) any health care plan;

(ii) any owner, officer, director, or manager of any health care plan;

(iii) any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable medical equipment;

(iv) any facility at which a health service would be provided;

(v) any officer, director, partner, or manager of a physician's medical group, independent practice association, or facility at which a health care service would be provided; or

(vi) any developer or manufacturer of a health service or product.

(c) Following certification:

(1) if an IDRE acquires control of, becomes controlled by, or comes under common control with any entity described in subdivision (a) of this section, the IDRE shall notify the superintendent in writing within three business days of the acquisition or exercise of control and shall no longer be eligible to review disputes; and

(2) the sworn statement required by subdivision (b) of this section shall be amended and resubmitted to the superintendent within three business days of the addition or deletion of any material affiliation as described in subdivision (a) of this section.

(d) An IDRE, or an officer, director, or manager thereof, or a reviewer or reviewing physician employed or engaged thereby to conduct any dispute resolution pursuant to Financial Services Law Article 6 shall not have any material professional affiliation, material familial affiliation, or material financial affiliation with:

(1) the health care plan;

(2) any officer, director, or manager of the health care plan;

(3) any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable medical equipment that provided or supplied the health care service;

(4) the facility at which the health service was provided;

(5) any officer, director, partner, or manager of the physician's medical group, independent practice association, or facility that provided the heath care service;

(6) the developer or manufacturer of the principal health service that is the subject of the dispute resolution; or

(7) the patient whose health care service is the subject of the dispute resolution.

(e) Unavoidable conflicts; minimization.

(1)(i) If the superintendent determines that a conflict exists to the dispute to be assigned and is unavoidable because all IDREs certified pursuant to this Part, or their medical directors, owners, officers, directors or managers, have a disqualifying material familial, financial or professional affiliation with one or more of the persons or entities listed in subdivision (b) of this section, the superintendent will make a random assignment of the dispute, provided that the IDRE assigned shall, within two business days of the assignment, certify to the superintendent by sworn statement that the reviewer and reviewing physician who will review the dispute have been assigned in accordance with paragraph (2) of this subdivision.

(ii) When a dispute must be assigned pursuant to this paragraph, the superintendent will notify the health care plan, physician, and, as applicable, the provider and patient, that all IDREs have a proscribed material familial, financial or professional affiliation; of the need to randomly assign the dispute to a certified IDRE in order that a determination of the dispute be obtained; of the nature of the affiliation involving the IDRE assigned to the dispute; and that the IDRE's reviewer and reviewing physician who review the dispute shall not have any affiliation proscribed by this section.

(2) An IDRE assigned pursuant to this Part shall not assign a dispute resolution to a reviewer or reviewing physician who has a material familial, financial or professional affiliation with any of those persons listed in subdivision (d) of this section.

Section 400.5 Responsibilities of health care plans for disputes regarding emergency services and surprise bills.

(a) Upon receipt of a claim for emergency services rendered by a non-participating physician, a health care plan shall:

(1) pay the claim, within the timeframes established in Insurance Law section 3224-a, in an amount that it deems reasonable for the emergency services rendered by the non-participating physician, except for the insured's co-payment, coinsurance or deductible, if any. Nothing shall preclude the health care plan from attempting to negotiate the reimbursement amount with the non-participating physician within the timeframes established in Insurance Law section 3224-a;

(2) if the claim is submitted by the non-participating physician, or if payment is made to the non-participating physician, provide notice to the non-participating physician describing how to initiate the independent dispute resolution process; and

(3) if the health care plan pays an amount less than the non-participating physician's charge, provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician;

(ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician; and

(iii) direct the insured to contact the health care plan in the event that the non-participating physician bills the insured for the out-of-network service.

(b) Upon receipt of a claim for a surprise bill that is submitted with an assignment of benefits form, or that the health care plan otherwise determines is a surprise bill, the health care plan shall:

(1) pay the non-participating physician or non-participating referred health care provider the billed amount or attempt to negotiate reimbursement with the non-participating physician or non-participating referred health care provider. If the health care plan's attempts to negotiate reimbursement for the health care services provided by the non-participating physician or non-participating referred health care provider do not result in a resolution of the payment dispute, the health care plan shall pay the non-participating physician or non-participating referred health care provider an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance or deductible, in accordance with the timeframes established in Insurance Law section 3224-a;

(2) provide notice to the non-participating physician or, as applicable, to the non-participating referred health care provider, describing how to initiate the independent dispute resolution process; and

(3) provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or health care provider;

(ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician or non-participating referred health care provider; and

(iii) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service.

(c) Upon receipt of a claim for the services of a non-participating physician or a non-participating referred health care provider that could be a surprise bill that is not submitted with an assignment of benefits form, the health care plan shall provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall advise the insured that the claim could be a surprise bill and that the insured should contact the health care plan or visit the health care plan's website for additional information.

(d) If the health care plan receives a claim for services of a non-participating health care provider that is not submitted with an assignment of benefits form and the health care plan denies the claim because the health

care provider is a non-participating provider, the health care plan shall, upon receipt of the assignment of benefits form, comply with the requirements of subdivision (b) of this section.

(e) If the health care plan receives a claim for services of a non-participating health care provider that is not submitted with an assignment of benefits form and pays the claim, the health care plan shall, upon receipt of the assignment of benefits form, determine whether it will attempt to negotiate additional reimbursement with the non-participating physician or non-participating referred health care provider. After receipt of the assignment of benefits form, if the health care plan attempts to negotiate additional reimbursement for the surprise bill and the attempts do not result in a resolution of the payment dispute or the health care plan does not attempt to negotiate the additional reimbursement for the surprise bill, the health care plan shall:

(1) pay the non-participating physician or non-participating referred health care provider any additional amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance or deductible, in accordance with the timeframes established in Insurance Law section 3224-a; and

(2) provide the insured with notice that shall:

(i) explain that the insured will incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or health care provider;

(ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician or non-participating referred health care provider;

(iii) explain that if the health care plan paid the insured directly, then the insured must remit that payment to the non-participating physician or non-participating referred health care provider;

(iv) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service; and

(v) direct the insured to the health care plan's website for additional information regarding surprise bills.

(f) A health care plan shall prominently post on its website the information in paragraphs (1) – (5) of this subdivision and include in disclosure materials provided to insureds pursuant to Insurance Law sections 3217-a(a), 4324(a) and Public Health Law section 4408(1) the information in paragraphs (1) – (4) of this subdivision, as follows:

(1) a description of what constitutes a surprise bill;

(2) a description of the independent dispute resolution process;

(3) an assignment of benefits form for surprise bills;

(4) the health care plan's designated electronic and mailing address where the assignment of benefits form can be submitted; and

(5) information on how an insured, non-participating physician or, as applicable, a non-participating referred health care provider, may submit a dispute to an IDRE.

(g) An assignment of benefits form shall be in a form prescribed by the superintendent.

(h) A health care plan shall ensure that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or participating health care provider:

(1) for emergency services subject to Insurance Law section 3241(c) upon policy or contract issuance or renewal on and after March 31, 2015 and for emergency services listed in Financial Services Law section 602(b) on March 31, 2015 regardless of policy or contract issuance or renewal; and

(2) for a dispute involving a surprise bill when the insured has assigned benefits to a non-participating physician or a non-participating referred health care provider.

(i) If the IDRE directs the health care plan to engage in negotiations with the non-participating physician or non-participating referred health care provider the health care plan shall do so in good faith. If a settlement is reached, the health care plan shall notify the IDRE within two business days of the settlement and shall make any additional payment to the non-participating physician or non-participating referred health care provider within the timeframes prescribed in Insurance Law section 3224-a. If a settlement is not reached or the parties agree that a settlement is not attainable, the health care plan shall promptly notify the IDRE no later than the end of the time period granted by the IDRE for negotiation.

(j) If the IDRE issues a determination in favor of the non-participating physician or non-participating referred health care provider, the health care plan shall pay the non-participating physician or, as applicable, the non-participating referred health care provider, any additional amount owed within 30 days from the date of the determination.

(k) A health care plan shall designate, and inform the superintendent of, at least one officer and one staff member knowledgeable about the independent dispute resolution process who shall be responsible for oversight of the health care plan's compliance with the independent dispute resolution process. The health care plan shall make at least one staff person available during normal business hours for not less than 40 hours per week. The health care plan shall respond to all inquiries from the superintendent relating to the dispute resolution process within three business days.

Section 400.6 Responsibilities of physicians and non-participating referred health care providers for disputes regarding emergency services and surprise bills.

(a) If a physician bills a patient for a surprise bill, the physician shall provide a claim form to the patient and an assignment of benefits form in a form prescribed by the superintendent.

(b) If an insured assigns benefits for a surprise bill in writing to a non-participating physician or non-participating referred health care provider that knows the insured is insured under a health care plan, the non-participating physician or non-participating referred health care provider shall not bill or seek payment from the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

(c) If a health care plan attempts to negotiate reimbursement with a non-participating physician or non-participating referred health care provider, the non-participating physician or non-participating referred health care provider shall have at least seven business days to respond to the health care plan's offer, except when the seven business days would exceed the timeframes established in Insurance Law section 3224-a for a health care plan to pay a claim.

(d) If the IDRE directs the non-participating physician or non-participating referred health care provider to engage in negotiations with the health care plan, the non-participating physician or non-participating referred health care provider shall do so in good faith. If a settlement is reached, the non-participating physician or non-participating referred health care provider shall notify the IDRE within two business days of the settlement. If a settlement is not reached or the parties agree that a settlement is not attainable, the non-participating physician or non-participating referred health care provider shall promptly notify the IDRE no later than the end of the time period granted by the IDRE for negotiation.

(e) A non-participating physician or non-participating referred health care provider shall respond to all inquiries from the superintendent relating to the dispute resolution process within three business days.

Section 400.7 Process to submit disputes regarding emergency services or surprise bills.

(a)(1) Emergency services. A health care plan, a non-participating physician or a patient who is not an insured may submit a dispute regarding emergency services rendered by a physician to the superintendent for review by an IDRE.

(2) Surprise bills. A health care plan, a non-participating physician, a non-participating referred health care provider, an insured who does not assign benefits, or a patient who is not an insured may submit a dispute regarding a surprise bill to the superintendent for review by an IDRE.

(b) The dispute shall be submitted by completing an application in a form and manner prescribed by the superintendent.

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

(1) the name and contact information of the health care plan;

(2) the name and contact information of the non-participating physician or non-participating referred health care provider;

(3) the fee charged by the non-participating physician or non-participating referred health care provider for the service that is the subject of the dispute, and provide a copy of the bill;

(4) the fee paid to the non-participating physician or non-participating referred health care provider for the service that is the subject of the dispute;

(5) at least three fees paid in the last 24 months by the health care plan to reimburse similarly qualified non-participating physicians or, if the dispute involves a health care provider, a non-participating health care provider for the same services in the same region that reflect the final and full payment to the non-participating physician or the non-participating health care provider, if available;

(6) an explanation of the circumstances and complexity of the particular case, including time and place of the service, if available;

(7) individual patient characteristics, if available;

(8) 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;

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

(10) an attestation affirming that the information provided by the health care plan is true and accurate; and

(11) any information requested by the IDRE.

(d) A physician or health care provider shall provide the following information:

(1) the name and contact information of the physician or non-participating referred health care provider;

(2) the name and contact information of the health care plan;

(3) the fee charged by the physician or non-participating referred health care provider for the service that is the subject of the dispute and a copy of the bill;

(4) the fee paid to the physician or non-participating referred health care provider for the service that is the subject of the dispute;

(5) at least three fees paid to the physician or, if the dispute involves a health care provider to the non-participating referred health care provider, in the last 24 months for the same services rendered by the physician or non-participating referred health care provider to other patients in health care plans in which the physician or non-participating referred health care provider is not participating that reflect the final and full payment to the non-participating physician or the non-participating health care provider, if available;

(6) the physician'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 or non-participating referred health care provider is not participating;

(7) the physician's or non-participating referred health care provider's level of training, education and experience;

(8) an explanation of the circumstances and complexity of the particular case, including time and place of the service;

(9) individual patient characteristics;

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

(11) an attestation affirming that the information provided by the physician or non-participating referred health care provider is true and accurate; and

(12) any information requested by the IDRE.

(e) Patients submitting the dispute shall provide the following information:

(1) the name and contact information of the patient;

(2) the name and contact information of the physician or non-participating referred health care provider;

(3) the name and contact information of the health care plan, if the patient is an insured;

(4) the fee charged by the physician or non-participating referred health care provider for the service that is the subject of the dispute and a copy of the bill;

(5) an explanation of the circumstances and complexity of the particular case, including time and place of the service;

(6) individual patient characteristics, if available;

(7) any other information the patient deems relevant;

(8) a consent to the release of medical information;

(9) with respect to a patient who is not an insured and who requests a waiver of the fee based on hardship, information to demonstrate that the patient is eligible for a hardship exemption;

(10) with respect to a patient who is not an insured and submits a dispute for a surprise bill, a statement that the required disclosures have not been provided;

(11) an attestation affirming that the information provided by the patient is true and accurate; and

(12) any information requested by the IDRE.

(f) A patient shall not be required to pay the physician's or non-participating referred health care provider's fee in order to be eligible to submit the dispute for review to an IDRE.

(g) A health care plan, physician, non-participating referred health care provider or patient shall provide any information requested by an IDRE as soon as possible, but no later than the timeframe requested by the IDRE, as provided under 400.8 of this Part.

Section 400.8 Responsibilities of an IDRE.

(a) Within three business days of receipt of an application submitted by a health care plan, non-participating physician, 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 or non-participating referred health care provider:

(1) screen the application for eligibility;

(2) contact the health care plan, physician 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 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 or non-participating referred health care provider's application is eligible, or within three business days of receipt of the patient's application from the superintendent, the IDRE shall send notification of the assignment to the health care plan, physician, non-participating referred health care provider and, for a patient initiated application, to the patient. The IDRE shall include in the notification:

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

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

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

(4) a statement that all information must be submitted within five business days of the notification;

(5) a statement that if a partial response or no response is received, the dispute will be decided based on the available information; and

(6) a statement that the IDRE shall not reconsider a dispute for which a determination has been made based upon receipt of additional information subsequent to such determination.

(d) If the requested information is not received within five 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.

(e) If the IDRE determines, in a case involving a health care plan, based on the health care plan's payment and the non-participating physician's or non-participating referred health care provider's fee, that a settlement between the health care plan and the non-participating physician or non-participating referred health care provider is reasonably likely, or that both the health care plan's payment and the non-participating physician's or non-participating referred health care provider's fee 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 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 day period for dispute resolution.

(f) 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) An IDRE shall make a determination within 30 days of receiving the request for the dispute resolution.

(h) 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 the non-participating physician's or, as applicable, the non-participating referred health care provider's fee. For disputes that do not involve a health care plan, the IDRE shall determine a reasonable fee.

(i) An IDRE shall use the conditions and factors set forth in Financial Services Law section 604 when determining the reasonable fee.

(j) An IDRE shall forward copies of the dispute resolution determination to the health care plan, physician 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 or non-participating referred health care provider, the fee paid by the health care plan, the usual and customary charge, 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 does not prevail.

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

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

Section 400.9 IDRE record retention and compliance.

(a) An IDRE shall retain case records in accordance with 11 NYCRR 243 (Insurance Regulation 152) for audit and examination for a period of six years from the date of the IDRE's determination. The IDRE shall keep and maintain all documentation relating to a case for no less than six years from the date of the IDRE's determination. The IDRE shall maintain on file each attestation required to be submitted pursuant to section 400.3(a)(4)(ii) for six years from the date of the IDRE's determination.

(b) An IDRE shall ensure the confidentiality of medical and treatment records and review materials in accordance with 11 NYCRR 420 (Insurance Regulation 169) and 11 NYCRR 421 (Insurance Regulation 173) relating to the privacy and confidentiality of health information.

(c) Every attestation required to be submitted pursuant to section 400.3(a)(4)(ii) of this Part shall be in a form prescribed by the superintendent.

(d) An IDRE shall be subject to examination by the superintendent at any time to ascertain compliance with Financial Services Law Article 6 and this Part.

(e) An IDRE shall provide ready access to the superintendent to all data, records, and information collected and maintained concerning the IDRE's dispute resolution activities.

(f) An IDRE shall provide the superintendent data, information, and reports as the superintendent determines necessary to evaluate the dispute resolution process within two business days or such other period acceptable to the superintendent.

(g) An IDRE shall consent to cooperate in court proceedings relevant to its role as an IDRE.

(h) The superintendent may suspend IDRE case assignment if the IDRE fails to comply with any of the requirements of this Part and the superintendent may require all necessary corrective actions be taken by the IDRE.

Section 400.10 Payment for the independent dispute resolution.

(a) Disputes involving an insured.

(1) If an IDRE determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician or as applicable, non-participating referred health care provider.

(2) If an IDRE determines the non-participating physician's or non-participating referred health care provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan.

(3) If good faith negotiations directed by the IDRE results in a settlement between the health care plan and the non-participating physician or non-participating referred health care provider, the health care plan and the non-participating physician or non-participating referred health care provider shall evenly divide and share the prorated cost for dispute resolution.

(4) For disputes that are rejected as ineligible or due to the requesting non-participating physician, non-participating referred health care provider or health care plan's failure to submit information, an IDRE may charge an application processing fee, which shall be the responsibility of the requesting physician, health care provider or health care plan.

(b) Disputes involving a patient who is not an insured.

(1) If an IDRE determines the physician's fee is reasonable, payment for the independent dispute resolution process shall be the responsibility of the patient. If the superintendent determines that payment would pose a hardship to the patient pursuant to subdivision (c) of this section, the IDRE shall waive payment for the dispute resolution process.

(2) If an IDRE determines the physician's fee is not reasonable, payment for the independent dispute resolution process shall be the responsibility of the physician.

(c) A hardship shall exist if the household income of the patient who is not an insured is below 250 percent of the federal poverty level, as determined annually by the Secretary of Health and Human Services.

(d) Any 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.

NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

I, Benjamin M. Lawsky, Superintendent of Financial Services, do hereby certify that the foregoing is new Part 400 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York, signed by me on May 19 , 2015, pursuant to the authority granted by Sections 202, 301, 302 and Article 6 of the Financial Services Law, Section 301 of the Insurance Law, and Part H of Chapter 60 of the Laws of 2014, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed rule was published in the State Register on December 31, 2014 and prior notice of the revised proposed rule was published in the State Register on April 1, 2015. No other publication or prior notice is required by statute.

Benjamin M. Lawsky
Superintendent of Financial Services

Dated: May 19, 2015

* ARTICLE 6

EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS

Section 601. Dispute resolution process established.
602. Applicability.
603. Definitions.
604. Criteria for determining a reasonable fee.
605. Dispute resolution for emergency services.
606. Hold harmless and assignment of benefits for surprise bills for insureds.
607. Dispute resolution for surprise bills.
608. Payment for independent dispute resolution entity.

* NB Effective March 31, 2015

* § 601. Dispute resolution process established. The superintendent shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The superintendent shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The superintendent shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this article. To the extent practicable, the physician shall be licensed in this state.

* § 602. Applicability. (a) This article shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law and article fifty-one of the insurance law, and shall not preempt any such law.

(b)(1) With regard to emergency services billed under American medical association current procedural terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in this article shall not apply when:

(A) the amount billed for any such CPT code meets the requirements set forth in paragraph three of this subsection, after any applicable co-insurance, co-payment and deductible; and

(B) the amount billed for any such CPT code does not exceed one hundred twenty percent of the usual and customary cost for such CPT code.

(2) The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this subsection than the insured would have incurred if such emergency services were provided by a participating physician.

(3) Beginning January first, two thousand fifteen and each January first thereafter, the superintendent shall publish on a website maintained by the department of financial services, and provide in writing to each health care plan, a dollar amount for which bills for the procedure codes identified in this subsection shall be exempt from the dispute resolution process established in this article. Such amount

shall equal the amount from the prior year, beginning with six hundred dollars in two thousand fourteen, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall an amount exceeding one thousand two hundred dollars for a specific CPT code billed be exempt from the dispute resolution process established in this article.

* § 603. Definitions. For the purposes of this article:

(a) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in : (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the social security act 42 U.S.C. § 1395dd.

(b) "Emergency services" means, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient.

(c) "Health care plan" means an insurer licensed to write accident and health insurance pursuant to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

(d) "Insured" means a patient covered under a health care plan's policy or contract.

(e) "Non-participating" means not having a contract with a health care plan to provide health care services to an insured.

(f) "Participating" means having a contract with a health care plan to provide health care services to an insured.

(g) "Patient" means a person who receives health care services, including emergency services, in this state.

(h) "Surprise bill" means a bill for health care services, other than emergency services, received by:

(1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received

for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;

(2) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan; or

(3) a patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not timely received all of the disclosures required pursuant to section twenty-four of the public health law.

(i) "Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.

* § 604. Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(a) whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(1) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating, and

(2) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan;

(b) the level of training, education and experience of the physician;

(c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;

(d) the circumstances and complexity of the particular case, including time and place of the service;

(e) individual patient characteristics; and

(f) the usual and customary cost of the service.

* § 605. Dispute resolution for emergency services. (a) Emergency services for an insured. (1) When a health care plan receives a bill for emergency services from a non-participating physician, the health care plan shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, in accordance with section three thousand two hundred twenty-four-a of the insurance law, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to

subsection (c) of section three thousand two hundred forty-one of the insurance law.

(2) A non-participating physician or a health care plan may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity.

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) Emergency services for a patient that is not an insured. (1) A patient that is not an insured or the patient's physician may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the superintendent.

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in section six hundred four of this article.

(3) A patient that is not an insured shall not be required to pay the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, physician and patient, and shall be admissible in any court proceeding between the health care plan, physician or patient, or in any administrative proceeding between this state and the physician.

* § 606. Hold harmless and assignment of benefits for surprise bills for insureds. When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

* § 607. Dispute resolution for surprise bills. (a) Surprise bill received by an insured who assigns benefits. (1) If an insured assigns benefits to a non-participating physician, the health care plan shall pay the non-participating physician in accordance with paragraphs two and three of this subsection.

(2) The non-participating physician may bill the health care plan for the health care services rendered, and the health care plan shall pay the non-participating physician the billed amount or attempt to

negotiate reimbursement with the non-participating physician.

(3) If the health care plan's attempts to negotiate reimbursement for health care services provided by a non-participating physician does not result in a resolution of the payment dispute between the non-participating physician and the health care plan, the health care plan shall pay the non-participating physician an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance or deductible, in accordance with section three thousand two hundred twenty-four-a of the insurance law.

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of paragraphs one, two and three of this subsection.

(5) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) Surprise bill received by an insured who does not assign benefits or by a patient who is not an insured. (1) An insured who does not assign benefits in accordance with subsection (a) of this section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in section six hundred four of this article.

(3) A patient or insured who does not assign benefits in accordance with subsection (a) of this section shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute entity.

(c) The determination of an independent dispute resolution entity shall be binding on the patient, physician and health care plan, and shall be admissible in any court proceeding between the patient or insured, physician or health care plan, or in any administrative proceeding between this state and the physician.

* § 608. Payment for independent dispute resolution entity. (a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the

non-participating physician. When the independent dispute resolution entity determines the non-participating physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to paragraph four of subsection (a) of section six hundred five of this article, or paragraph six of subsection (a) of section six hundred seven of this article results in a settlement between the health care plan and non-participating physician, the health care plan and the non-participating physician shall evenly divide and share the prorated cost for dispute resolution.

(b) For disputes involving a patient that is not an insured, when the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The superintendent shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.