(Laws of 2014, Chapter 355, as amended by Laws of 2019, Chapter 6, Section 9), and requirements for weighing environmental justice in UPA permitting. These requirements, however, apply statewide and to all applicants, where relevant. The CLCPA, CRRA and EJ requirements, together or separately, will likely result in additional application costs for projects that are subject to those requirements depending on the application and programmatic requirements that are still being developed.

3. Professional services:

Where an application is subject to CLCPA, CRRA or EJ, small businesses and local governments may need to engage consultants in responding to additional information requests for information on greenhouse gas emissions, flooding or impacts on EJ communities. DEC has no way of determining what these costs may be as they will depend on the application and on the programmatic requirements that are still to be developed.

4. Compliance costs:

In some cases, costs to regulated parties, including small businesses and local governments, may decrease because 621.4 increases the number of "minor projects." Minor projects do not require public notice (6 NYCRR 621.3[b][2]). Minor projects also have a shorter review period. Shorter review times indirectly reduce regulatory costs and regulatory uncertainty by speeding up review times. This change is a significant benefit for some smaller scale projects that fit into the Minor Project classification.

The rule that may increase cost to regulated parties that are asked to comply with CLCPA, CRRA and EJ (see proposed 6 NYCRR 621.3 (a)(11)-(13). CLCPA, CRRA and EJ are requirements that the Legislature made applicable to UPA permits. DEC has no control over that fact. Compliance costs (application related) will include responding to information requests or, where applicable, outreach in environmental justice communities. These costs depend on the application. Therefore, DEC cannot estimate them collectively or individually.

5. Economic and technological feasibility:

In complying with the proposed rule, there are no known economic or technological feasibility issues for small businesses and local governments.

6. Minimizing adverse impact:

The CLCPA, CRRA and EJ requirements are legislative requirements. The rule only specifies that DEC has authority to request additional information to comply with CLCPA, CRRA and EJ.

7. Small business and local government participation:

DEC staff made extensive outreach efforts to the consultant, legal and business community.

a. Albany Meetings on April 19, 2019 and July 22, 2019

DEC staff held a stakeholder meeting on April 19, 2019, in which they invited approximately twenty-five persons from the legal and consulting engineer community. These persons regularly represent persons and entities including municipal entities involved in UPA permitting matters. Of the approximately twenty-five invitees, seven persons attended the meeting. Much of the discussion centered around the difficulties in getting to a complete application. Attendees asked that process be made more transparent and offered the suggestion, among others, that DEC create completeness checklists for the different program areas as the Army Corp of Engineers has done for the permitting programs it administers. Attendees supported DEC's proposal to create more categories of minor permits. Attendees discussed clarifying what the phrase "significant degree of public interest" means in terms of the determination on whether to conduct a public hearing. In follow-up to the April 19, 2019 meeting, Elizabeth Morss, Esq., Young Sommer, wrote a letter to DEC staff expressing her views on, among other topics, the revised definition of completeness, public participation plans, and DEC's proposal to expand its authority to suspend applications for enforcement matters where the application does not involve the same site as that where the violation is alleged to have occurred. The letter (letter in response to stakeholder outreach) will be published on DEC's website alongside the other rule making documents.

DEC staff met on July 22, 2019 with members of the New York State Bar Association. Four attorneys attended the meeting.

b. Other Scheduled Meetings

DEC scheduled a separate stakeholder meeting for environmental groups (invites sent to Riverkeeper, Scenic Hudson, Protect the Adirondacks, Inc., and Adirondack Council) to occur on April 24, 2019. Only one group responded to the solicitation but then cancelled.

Staff also organized a stakeholder meeting to occur in Stony Brook, Long Island, on June 19, 2019. The invitees represented the consulting and environmental analyst community, who in turn represent municipal and industry participants in the UPA permitting process. There were eleven invitees but no acceptances. The meeting, therefore, was cancelled.

DEC staff scheduled additional stakeholder meetings in Buffalo on November 13, 2019 and then in Watertown on November 14, 2019. Together, thirteen persons representing the consulting and legal community were invited. As with the Albany stakeholders, these persons were selected inasmuch as they regularly represent individuals, corporations, and municipalities in the UPA permitting process. After nobody confirmed their attendance, the meetings were cancelled.

While interest in the rulemaking was limited based on participation, the meetings that were held, and those in attendance, proved very informative and beneficial to development of the proposed amendments. Overwhelmingly, stakeholders had one over-riding concern — which was the need for greater certainty in the regulatory process.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas:

The proposed rule applies statewide and includes all rural areas of the State.

2. Reporting, recordkeeping, and other compliance requirements; and professional services:

The rule does not establish additional reporting, recordkeeping or compliance requirements that are specific to rural areas. Under the rule the Department of Environmental Conservation (DEC) would have specific authority to ask for information to satisfy the requirements of the Climate Leadership and Community Protection Act (CLCPA; Laws of 2019, Chapter 106, as codified in ECL Article 75), the Community Risk and Resiliency Act (Laws of 2014, Chapter 355, as amended by Laws of 2019, Chapter 6, Section 9), and requirements for weighing environmental justice in certain UPA permitting. These requirements, however, apply statewide and are not specific to rural areas.

3. Costs:

The proposed rule will likely result in increased costs for rural applicants (as well as all applicants) subject to CLCPA, CRRA or EJ requirements. As discussed in the Regulatory Impact Statement, the newly proposed rule only codifies and specifies DEC's ability to seek additional information related to the newly legislated requirements under CLCPA, CRRA and EJ and for purposes of determining whether an application is complete. Thus, the new requirements are acts of the legislature, and DEC has no control over that fact.

4. Minimizing adverse impact:

The rule would not have adverse impacts on rural areas.

5. Rural area participation:

The proposed changes to UPA do not affect rural areas as distinct from other demographic or geographic regions of the state. Possible rural concerns are not distinct from the concerns of other stakeholders. Public participation is discussed generally in the Regulatory Flexibility Analysis for Small Businesses and Local Governments. Stakeholders who participated in the sessions described therein also represent stakeholders in rural areas as well as in other demographic and geographic areas of the State. Readers should refer to that discussion.

Job Impact Statement

The Department of Environmental Conservation has determined that the proposed amendments to the regulations that implement the Uniform Procedures Act (6 NYCRR Part 621) will not have a substantial adverse impact on jobs and employment opportunities and that this conclusion is evident from the text of the proposed rule. The Uniform Procedures Act is a procedural rule, and, as such, does not create new substantive and substantial obligations that impose additional costs on the economy.

Department of Financial Services

REVISED RULE MAKING NO HEARING(S) SCHEDULED

Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure

I.D. No. DFS-47-21-00006-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Proposed Action: Amendment of Part 52 (Regulation 62) of Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301, 302; Insurance Law, sections 301, 3217, 3217-a, 3217-b, 4324, 4325; Public Health Law, sections 4406-c, 4408; Federal No Surprises Act

Subject: Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure.

Purpose: Apply disclosure requirements to dental and vision and hold issuers responsible for inaccurate network status information.

Text of revised rule: Section 52.54(d) is added as follows:

(d) The disclosure requirements in Insurance Law sections 3217-a and

4324 shall apply to stand-alone dental insurance and stand-alone vision insurance.

A new section 52.77 is added as follows:

§ 52.77 Payment when an issuer provides inaccurate network status information.

(a) If an insured who is covered under an accident and health insurance policy that uses a network of health care providers receives a bill for out-of-network services resulting from an issuer providing inaccurate network status information to an insured, the issuer shall not impose on the insured a copayment, coinsurance, or deductible for the service that is greater than the copayment, coinsurance, or deductible that would be owed if the insured had received services from a participating provider. The issuer shall apply the out-of-pocket maximum that would have applied had the services been received from a participating provider.

(b) Pursuant to Insurance Law sections 3217-b(n) and 4325(o) and Public Health Law section 4406-c(12), if an issuer provides inaccurate network status information to an insured, the issuer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services.

(c) An issuer shall provide network status information to an insured in writing within one business day of the insured requesting the information by telephone.

(d) An issuer provides inaccurate network status information when:

(1) the issuer represents in the provider directory posted on its website that a non-participating provider is participating in the issuer's network;

(2) the issuer provides information, upon an insured's request made by telephone, that a non-participating provider is participating in the issuer's network;

(3) the issuer fails to provide information in writing regarding a specific provider's participating status within one business day of a request from an insured made by telephone; or

(4) the issuer represents in the hard copy provider directory that a provider is participating in the issuer's network and the provider is non-participating as of the date of publication of the hard copy provider directory.

(e) An issuer shall include in its hard copy provider directory a notification that the information contained in the directory was accurate as of the date of publication of such directory and that an insured should consult the provider directory posted on the issuer's website to obtain the most current provider directory information.

(f) As used in this section:

(1) Non-participating means not having an agreement with an issuer with respect to the rendering of health care services to an insured.

(2) Participating means having an agreement with an issuer with respect to the rendering of health care services to an insured.

(3) Issuer means an insurer licensed to write accident and health insurance in this State, 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, and a student health plan certified pursuant to Insurance Law section 1124.

(g) This section shall apply to all policies issued, renewed, modified, or amended on or after the effective date of this section.

Revised rule compared with proposed rule: Substantive revisions were made in sections 52.54(d) and 52.77.

Text of revised proposed rule and any required statements and analyses may be obtained from Colleen Rumsey, New York State Department of Financial Services, One Commerce Plaza, Albany, New York 12257, (518) 474-0154, email: Colleen.Rumsey@dfs.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Revised Regulatory Impact Statement

1. Statutory authority: Financial Services Law ("FSL") Sections 202, 301, and 302, Insurance Law ("IL") Sections 301, 3217, 3217-a, 3217-b, 4324, and 4325, Public Health Law ("PHL") Sections 4406-c and 4408, and the federal No Surprises Act (the "Federal Act").

FSL Section 202 establishes the office of the Superintendent of Financial Services ("Superintendent"). FSL Sections 301 and 302 and IL Section 301, in pertinent part, authorize the Superintendent to prescribe regulations interpreting the IL and to effectuate any power granted to the Superintendent in the IL, FSL, or any other law.

IL Section 3217 sets forth the minimum standards for the form, content, and sale of accident and health insurance policies and subscriber contracts (collectively, "health insurance policies") in relation to insurers licensed to write accident and health insurance in New York State, corporations organized pursuant to Insurance Law Article 43, municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47, health maintenance organizations ("HMOs") certified pursuant to PHL Article 44, and student health plans certified pursuant to IL Section 1124 (collectively, "issuers").

IL Sections 3217-a and 4324 set forth the disclosure of information requirements for comprehensive expense-reimbursed health insurance policies, managed care health insurance policies, and any other health insurance policy or product for which the Superintendent deems such disclosure appropriate.

IL Sections 3217-b and 4325 and PHL Section 4406-c set forth provider contract requirements for the provision of provider directory information and for reimbursement when an insured is provided with inaccurate network status information in relation to issuers subject to IL Article 32, organized under IL Article 43, or certified pursuant to PHL Article 44.

PHL Section 4408 sets forth the disclosure of information requirements for HMOs.

The Federal Act, in pertinent part, sets forth requirements for updating provider directory information and prohibits health insurance issuers from imposing a cost-sharing amount that is greater than the cost-sharing amount that would apply had the services been furnished by a participating provider when an insured receives information through a database, provider directory, or response protocol that a non-participating provider is a participating provider. These provisions of the Federal Act took effect for plan years beginning on or after January 1, 2022.

2. Legislative objectives: To protect health insurance consumers from surprise medical bills.

3. Needs and benefits: The Department of Financial Services ("Department") has received complaints that issuers are not updating their provider directories when a provider is terminated, and insureds rely on inaccurate information with the disastrous consequence of having to pay unexpected medical bills. Insureds who check the status of providers in their issuer's provider directory or request information from the issuer before obtaining health care services should not be responsible for unexpected bills for out-of-network services when provided with inaccurate information. Furthermore, insureds covered by stand-alone dental or stand-alone vision insurance should have the same protections that apply when a dental or vision benefit is embedded in a comprehensive policy.

The Federal Act prohibits issuers from imposing a cost-sharing amount, deductible, or out-of-pocket maximum that is greater than the amounts that would apply had the services been furnished by a participating provider when an issuer provides incorrect information, through an online database, hard copy provider directory, or in response to the insured's request, that a non-participating provider is a participating provider or fails to provide network status information within one business day of an insured's request (collectively "inaccurate network status information"). It requires issuers to include a notification in any printed provider directory that the information was accurate as of the date of publication of the directory and that an insured should consult the online provider directory to obtain the most current information. The Federal Act includes requirements for the provider to give provider directory information timely to an issuer. It also requires the provider to reimburse the insured for the amount paid by the insured in excess of the in-network cost-sharing amount, including interest, for the services involved when the insured is provided with inaccurate network status information by the issuer.

IL Sections 3217-b(m) and 4325(n) and PHL Section 4406-c(11), as amended by Part AA of Chapter 57 of the Laws of 2022 ("Part AA"), require that contracts between certain issuers and providers include a requirement for the provider to have in place a business process to ensure the timely provision of provider directory information to the issuer and to submit provider directory information to an issuer when the provider begins or terminates a network agreement with the issuer; when there are material changes to the provider directory information of the provider; and at any other time, including upon the issuer's request, as the provider determines to be appropriate. IL Sections 3217-b(n) and 4325(o) and PHL Section 4406-c(12), as amended by Part AA, also mandate that contracts between certain issuers and providers require a provider to reimburse an insured for amounts in excess of the in-network cost-sharing amount when the insured is provided with inaccurate network status information by the issuer. Furthermore, these sections of the IL provide that if an issuer provides inaccurate network status information to an insured, the issuer must reimburse the provider for the services regardless of whether the insured's coverage includes out-of-network services.

IL Sections 3217-a(a)(17) and 4324(a)(17) and PHL Section 4408(1)(r) require certain issuers to post provider directory information on their websites and update their websites within 15 days of the addition or termination of a provider from their network.

This amendment implements the requirements of Part AA and the Federal Act. It requires issuers to provide network status information to an insured, in writing, within one business day of the insured requesting the information by telephone. It prohibits an issuer from imposing on an insured a cost-sharing amount, deductible, or out-of-pocket maximum that is greater than the amounts that would apply if the insured had received

services from a participating provider. It also provides that if an issuer provides inaccurate network status information to an insured, the issuer must reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. The amendment requires an issuer to include in its hard copy provider directory a notification that the information contained in the directory was accurate as of the date of publication of such directory and that an insured should consult the provider directory posted on the issuer's website to obtain the most current provider directory information. It also applies the disclosure requirements in IL Sections 3217-a and 4324 to stand-alone dental and vision insurance to ensure that insureds covered under these policies are provided accurate and up-to date information. Finally, this amendment holds issuers responsible when they provide inaccurate network status information.

4. Costs: This amendment may impose costs on issuers of stand-alone dental or vision insurance to provide the required disclosures in IL Sections 3217-a and 4324; however, it is the Department's understanding that most issuers offering stand-alone dental or stand-alone vision insurance are already providing such disclosures. This amendment may also impose compliance costs on issuers that fail to make timely updates to their provider directories or that provide inaccurate information or fail to provide information in response to requests from insureds since they may only impose the in-network cost-sharing amount and must reimburse the provider for the out-of-network services, regardless of whether the insured's coverage includes out-of-network services. Issuers that timely update their provider directories and timely provide accurate information in response to requests from insureds will not have to impose in-network cost-sharing amounts or reimburse providers when they do not cover out-of-network services; thus, the actual additional cost to an issuer will be dependent upon the issuer's timeliness and accuracy. However, any additional costs are a result of the Federal Act and Part AA, and not this amendment, because this amendment implements the Federal Act and Part AA.

The Department may incur minimal costs for implementation and continuation of this amendment, but the Department should be able to absorb such costs in its ordinary budget.

This amendment does not impose any compliance costs on state or local governments or health care providers.

5. Local government mandates: This amendment does not impose any program, service, duty or responsibility upon a city, town, village, school district, or fire district.

6. Paperwork: The amendment imposes no new reporting requirements.

7. Duplication: This amendment does not duplicate, overlap, or conflict with any existing state or federal rules or other legal requirements.

8. Alternatives: The Department considered language that would require an issuer, if an insured receives a bill for out-of-network services resulting from the issuer providing inaccurate network status information to the insured, to ensure that the insured will incur no greater out-of-pocket costs for the services than would be owed if the insured received services from a participating provider. This language previously has been interpreted as requiring the issuer to pay the provider's actual charges in order to make the insured whole. However, because neither the Federal Act nor Part AA set a payment amount, and because both the issuer and the provider are responsible for ensuring that an insured is only responsible for paying the in-network cost-sharing, the Department removed this language and mirrored the language in the Federal Act. The federal government may issue a regulation or guidance addressing the payment amount at some point in the future. If and when such regulation or guidance is issued, issuers will be expected to comply with it.

The Department considered applying the obligations on issuers when they provide inaccurate network status information only to comprehensive health insurance policies that use a network of health care providers and not expanding the disclosure requirements in IL Sections 3217-a and 4324 to stand-alone dental and vision insurance; however, the new provisions in Part AA that amend IL Sections 3217-b and 4325 to set forth provider contract requirements for the provision of provider directory information and for reimbursement when an insured is provided with inaccurate network status information are not limited to comprehensive health insurance policies. Therefore, the Department applied the obligations on issuers to all accident and health insurance policies that use a network of health care providers, including stand-alone dental and stand-alone vision insurance. The Department considered a request that the one business day timeframe for an issuer to respond to an insured's telephone request for network status information be changed to three business days and a request that the Department consider "the date of publication" of the hard copy provider directory to be the last date information was imported prior to being finalized and sent to the printer. The Department did not make these changes because the current requirements are consistent with the Federal Act. If an issuer fails to comply with these requirements, the issuer will be deemed to have provided inaccurate network status information and must not impose a copayment, coinsurance, or deductible that is greater than what would apply if the service was provided by a participating provider.

The Department considered a request that the amendment require providers to report provider directory information timely to the issuer and the insured. The Department did not make this change because the Federal Act and Part AA already require providers to report provider directory information timely to issuers and because the amendment only addresses issuer requirements.

9. Federal standards: The amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: Issuers will need to comply with this amendment for policies and contracts issued, renewed, modified, or amended on and after the publication of the notice of adoption in the State Register. However, issuers should be complying already with the requirements of the Federal Act upon policy issuance or renewal on and after January 1, 2022 and complying with the requirements of Part AA as of April 9, 2022.

Revised Regulatory Flexibility Analysis

1. Effect of rule: This amendment implements the federal No Surprises Act (the "Federal Act") and Part AA of Chapter 57 of the Laws of 2022 ("Part AA"), the relevant provisions of which took effect for plan years beginning on or after January 1, 2022, and on April 9, 2022, respectively, and applies to insurers licensed to write accident and health insurance in New York State, corporations organized pursuant to Insurance Law Article 43, municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47, health maintenance organizations certified pursuant to Public Health Law Article 44, and student health plans certified pursuant to Insurance Law Section 1124 (collectively, "issuers"). Among other things, the amendment applies the disclosure requirements in Insurance Law Sections 3217-a and 4324 to stand-alone dental insurance and stand-alone vision insurance and prohibits an issuer of an accident and health insurance policy that uses a network of health care providers from imposing a copayment, coinsurance, or deductible that is greater than the copayment, coinsurance, or deductible that would be owed if the insured had received services from a participating provider when the issuer incorrectly lists a provider as participating in its online or hard copy provider directory, provides information upon an insured's request that a non-participating provider is participating, or fails to provide information regarding a specific provider's participating status within one business day of a request from an insured. The amendment also requires an issuer to apply the out-of-pocket maximum that would have applied had the services been received from a participating provider. Finally, it requires an issuer, if the issuer provides inaccurate network status information to an insured, to reimburse the provider for the out-of-network services, regardless of whether the insured's coverage includes out-of-network services.

Industry has asserted that certain issuers subject to the amendment are small businesses. An issuer that may be a small business subject to the amendment may incur additional costs. The costs are difficult to estimate and will vary by issuer because of several factors. However, most of the additional costs incurred are a result of the Federal Act and Part AA because this amendment implements the Federal Act and Part AA.

This amendment does not affect local governments.

2. Compliance requirements: A local government will not have to undertake any reporting, recordkeeping, or other affirmative acts to comply with the amendment since the amendment does not apply to a local government.

An issuer that is a small business will not have to undertake any additional reporting, recordkeeping, or other affirmative acts. To the extent there are additional compliance requirements, they are mainly a result of the Federal Act and Part AA, and not the amendment, because the amendment implements the Federal Act and Part AA.

3. Professional services: No local government will need professional services to comply with this amendment because the amendment does not apply to any local government. No issuer that is a small business should need to retain professional services, such as lawyers or auditors, to comply with this amendment.

4. Compliance costs: No local government will incur any costs to comply with this amendment because the amendment does not apply to any local government.

An issuer that issues stand-alone dental or stand-alone vision insurance may incur costs to comply with the disclosure requirements in Insurance Law Sections 3217-a and 4324, but it is the Department's understanding that most stand-alone dental and vision issuers are already providing such disclosures. An issuer that is a small business and that provides inaccurate provider directory information to insureds may incur costs to comply with this amendment because it must not charge a cost-sharing amount that is greater than the cost-sharing amount that would be owed if an insured had received services from a participating provider and it must reimburse the provider for the out-of-network services, regardless of whether the insured's coverage includes out-of-network services. However, any additional costs incurred are a result of the Federal Act and Part AA because this amendment implements the Federal Act and Part AA.

5. Economic and technological feasibility: This amendment does not apply to any local government; therefore, no local government should experience any economic or technological impact as a result of the amendment. An issuer that is a small business should not incur any economic or technological impact as a result of the amendment.

6. Minimizing adverse impact: There will not be an adverse impact on any local government because the amendment does not apply to any local government. This amendment should not have an adverse impact on an issuer that is a small business because the amendment uniformly affects all issuers. However, to the extent there is an adverse impact on an issuer that is a small business, it is a result of the Federal Act and Part AA, and not this amendment, because this amendment implements the Federal Act and Part AA.

7. Small business and local government participation: In October 2021, the Department of Financial Services ("Department") posted a draft regulation on its website for informal outreach and comments and notified trade organizations that represent issuers that may be small businesses of the posting, in compliance with State Administrative Procedures Act Section 202-b(6). Issuers that are small businesses also had an opportunity to participate in the rulemaking process when the proposed amendment was published in the State Register on November 24, 2021.

Revised Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: Insurers licensed to write accident and health insurance in New York State, corporations organized pursuant to Insurance Law Article 43, municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47, health maintenance organizations certified pursuant to Public Health Law Article 44, and student health plans certified pursuant to Insurance Law Section 1124 (collectively, "issuers") affected by this amendment operate in every county in New York State, including rural areas as defined by State Administrative Procedure Act Section 102(10).

2. Reporting, recordkeeping, and other compliance requirements; and professional services: This amendment imposes no new reporting, recordkeeping, or other compliance requirements. Any additional compliance requirements are a result of the federal No Surprises Act (the "Federal Act") and Part AA of Chapter 57 of the Laws of 2022 ("Part AA"), and not the amendment, because the amendment implements the Federal Act and Part AA.

Issuers, including those in a rural area, should not need to retain professional services, such as lawyers or auditors, to comply with this amendment.

3. Costs: This amendment may impose compliance costs on issuers, including those in a rural area, that issue stand-alone dental or stand-alone vision insurance to comply with the disclosure requirements in Insurance Law Sections 3217-a and 4324, but it is the Department's understanding that most stand-alone dental and vision issuers are already providing such disclosures. This amendment may also impose compliance costs on issuers, including those in a rural area, that provide inaccurate provider directory information to insureds. Issuers that fail to make timely updates to their provider directories or that provide inaccurate information or fail to provide information in response to requests from insureds must not charge a cost-sharing amount that is greater than the cost-sharing amount that would be owed if the insured had received services from a participating provider and must reimburse the provider for the out-of-network services, regardless of whether the insured's coverage includes out-of-network services. Issuers that timely update their provider directories and provide accurate information in response to requests from insureds will not have to impose in-network cost-sharing amounts or reimburse providers when they do not cover out-of-network services, and thus the actual additional cost to the issuer will be dependent upon the issuer's timeliness and accuracy. However, any additional costs are a result of the Federal Act and Part AA, and not this amendment, because this amendment implements the Federal Act and Part AA.

4. Minimizing adverse impact: This amendment uniformly affects issuers that are located in both rural and non-rural areas of New York State. The amendment should not have an adverse impact on rural areas.

5. Rural area participation: In October 2021, the Department posted the draft regulation on its website for informal outreach and comments and notified trade organizations of the posting. Issuers in rural areas were also given an opportunity to participate in the rulemaking process when the proposed amendment was published in the State Register on November 24, 2021.

Revised Job Impact Statement

The revised proposed amendment implements the requirements of Part H of Chapter 60 of the Laws of 2014, Part AA of Chapter 57 of the Laws of 2022, and the federal No Surprises Act (the "Federal Act"), which require insurers licensed to write accident and health insurance in New York State, corporations organized pursuant to Insurance Law Article 43, municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47, health maintenance organizations certified pursuant to Public Health Law Article 44, and student health plans certified pursuant to Insurance Law Section 1124 (collectively, "issuers") to post provider directory information on their websites, make timely updates to their websites, and to reimburse providers for out-of-network services if an issuer provides inaccurate network status information. The Federal Act also prohibits an issuer from imposing on an insured a cost-sharing amount that is greater than the cost-sharing amount that would be owed if the insured had received services from a participating provider when the insured receives a bill for out-of-network services resulting from an issuer providing inaccurate network status information to the insured. Accordingly, the amendment applies the disclosure requirements in Insurance Law Sections 3217-a and 4324 to stand-alone dental insurance and stand-alone vision insurance and prohibits an issuer of an accident and health insurance policy that uses a network of health care providers from imposing on an insured a copayment, coinsurance, or deductible that is greater than the copayment, coinsurance, or deductible that would be owed if the insured had received services from a participating provider when the issuer fails to make timely updates to its provider directory information or fails to provide accurate information in response to a request from an insured. It also requires an issuer to reimburse the provider for out-of-network services if the issuer provides inaccurate network status information to an insured. The Department of Financial Services does not anticipate that any issuer subject to this amendment will reduce its workforce or vendor services due to this amendment, and therefore finds that this amendment should not have a substantial adverse impact on jobs or employment opportunities in New York State.

Assessment of Public Comment

The New York State Department of Financial Services ("Department") received comments from associations that represent insurers and health maintenance organizations (collectively, "issuers") and from an association that represents hospitals. The comments requested changes and expressed concerns about the proposed regulation's requirements.

Comment: The proposed regulation requires that if an insured who is covered under a comprehensive health insurance policy that uses a network of health care providers receives a bill for out-of-network services resulting from an issuer providing inaccurate network status information to an insured, then the issuer must ensure that the insured will incur no greater out-of-pocket costs for the services than would be owed if the insured had received services from a participating provider. One commenter expressed concern that the federal No Surprises Act (the "Federal Act") only requires an issuer to charge in-network cost-sharing when an insured relies on inaccurate network status information and does not require an issuer to pay a provider any particular amount. The commenter stated that a provider is required to accept the issuer's payment as payment in full, thereby protecting the insured from balance billing. The commenter suggested that the language in the proposed regulation requiring issuers to "ensure that the insured will incur no greater out-of-pocket costs for the services than would be owed if the insured had received services from a participating provider" should be deleted.

Response: The Department agrees that there is no set payment amount under the Federal Act when an insured relies on inaccurate network status information; however, there is also no requirement that a provider accept the issuer's payment as payment in full. The Federal Act provides that: (1) an issuer cannot impose a cost-sharing amount that is greater than the cost-sharing amount that would apply if the service was provided by a participating provider; and (2) a provider must reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount if the provider submits a bill that is in excess of the normal cost-sharing applied for such services provided in-network, including interest. Furthermore, Part AA of Chapter 57 of the Laws of 2022 ("Part AA") amended Insurance Law Sections 3217-b and 4325 to provide that a contract between an issuer and a health care provider must include a provision that states that the provider will reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest, for the services involved when the insured is provided with inaccurate network status information by the issuer. Part AA also provides that if an issuer provides inaccurate network status information to an insured, the issuer must reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. However, neither the Federal Act nor Part AA address the payment amount.

Therefore, to address the concern raised in the comment and the new language in Part AA, and to ensure that the regulation is consistent with the requirements of the Federal Act, the Department amended the regulation to replace the language requiring issuers to "ensure that the insured will incur no greater out-of-pocket costs for the services than would be owed if the insured had received services from a participating provider"

with language stating that an issuer shall not impose a copayment, coinsurance, or deductible that is greater than the copayment, coinsurance, or deductible that would apply if the service were provided by a participating provider. To further address the language in Part AA, the Department also amended the regulation to add a new provision stating that if an issuer provides inaccurate network status information to an insured, the issuer must reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. However, this regulation does not address the payment amount since the Federal Act and New York State law do not address the payment amount. The federal government may issue a regulation or guidance addressing the payment amount at some point in the future. If and when such regulation or guidance is issued, issuers will be expected to comply with it.

Comment: The proposed regulation applies to comprehensive health insurance policies that use a network of health care providers. One commenter pointed out that the new provisions in Part AA that amend Insurance Law Sections 3217-b and 4325 to set forth provider contract requirements for the provision of provider directory information and for reimbursement when an insured is provided with inaccurate network status information, as described above, are not limited to comprehensive health insurance policies, but that the disclosure requirements in Insurance Law Sections 3217-a and 4324, which require issuers to provide certain disclosures, including provider directory information, to insureds are limited to comprehensive health insurance policies or products for which the superintendent deems such disclosure appropriate. The commenter asked the Department to confirm, since the disclosure requirements in Insurance Law Sections 3217-a and 4324 do not currently apply to stand-alone dental or stand-alone vision policies, that the new requirements in Insurance Law Sections 3217-b and 4325 relating to provider and issuer responsibilities when an insured is provided with inaccurate network status information also do not apply to stand-alone dental or stand-alone vision policies.

Response: The Legislature did not limit the changes in Insurance Law Sections 3217-b and 4325 to comprehensive health insurance policies. As such, the requirements would apply to stand-alone coverages, including stand-alone dental and stand-alone vision insurance coverages. Therefore, to address the concern raised in the comment and the new language in Part AA, the Department amended the regulation to clarify that the obligations on issuers when they provide inaccurate network status information apply to all accident and health insurance policies that use a network of health care providers, rather than only to comprehensive health insurance policies that use a network of health care providers. The Department also amended the regulation to include a provision stating that the disclosure requirements in Insurance Law Sections 3217-a and 4324 shall apply to stand-alone dental and stand-alone vision insurance.

Comment: Another commenter expressed support for the requirement that an issuer hold an insured harmless for any amounts exceeding the in-network cost-sharing when the insured relies on inaccurate information from the issuer but expressed concern that providers would be unfairly held responsible for issuers' misinformation. The commenter requested that the Department ensure that providers are not held responsible for issuers' mistakes by requiring issuers to make providers whole if providers are required to issue refunds to individuals.

Response: Part AA requires issuers that provide inaccurate network status information to an insured to reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Therefore, as stated above, the Department amended the regulation to add this requirement. However, this regulation does not address the payment amount since the Federal Act and New York State law do not address the payment amount at this time. Until a federal regulation or guidance addressing the payment amount is issued, issuers and providers must work out payment for out-of-network bills resulting from provider directory misinformation, while keeping the insured out of disputes over such bills, and must ensure that the insured is only responsible for paying the insured's in-network cost-sharing. Both the Federal Act and Part AA allow the provider contract to require the issuer to remove, at the time of termination of the provider contract, the provider from a directory and to require that the issuer bear financial responsibility for providing inaccurate network status information to an insured. Therefore, providers and issuers can address financial responsibility through provider contracts.

Comment: The proposed regulation requires an issuer to provide network status information to an insured in writing within one business day of the insured requesting the information by telephone. One commenter expressed concern that one business day is too short and suggested that the one business day requirement be changed to at least three days.

Response: The Department did not make this change because the one business day requirement is consistent with the requirements of the Federal Act.

Comment: The proposed regulation requires an issuer to include in its hard copy provider directory a notification that the information contained in the directory was accurate as of the date of publication of such directory and that an insured should consult the provider directory posted on the issuer's website to obtain the most current provider directory information. One commenter expressed concern that due to the time required to gather and verify provider directory information and the time necessary to test and approve the directory, there is a lag between when the information is imported into the provider directory and when the directory is printed. The commenter stated that due to this lag, provider directories are often already out of date by the print date. The commenter requested clarification that the Department will consider the "date of publication" to be the last date that information was imported prior to being finalized and sent to the printer.

Response: The Department did not make this change because the requirement that an issuer include in its hard copy provider directory a notification that the information contained in the directory was accurate as of the date of publication of such directory is consistent with the requirements of the Federal Act. If an issuer represents in the hard copy provider directory that a provider is participating in the issuer's network and the provider is non-participating as of the date of publication of the hard copy provider directory, the issuer will be deemed to have provided inaccurate network status information and must not impose on the insured a copayment, coinsurance, or deductible that is greater than the copayment, coinsurance, or deductible that would apply if the service were provided by a participating provider.

Comment: One commenter expressed concern that there should be some onus on the provider to report provider directory information timely to the issuer and the insured. The commenter requested that the Department consider including language in the regulation that requires providers to make timely provision of provider directory information to issuers.

Response: The Federal Act and Part AA require providers to report provider directory information timely to issuers. The proposed regulation only addresses issuer requirements, as the Department does not regulate providers. Therefore, the Department did not make any changes in response to this comment.

Department of Health

EMERGENCY RULE MAKING

Investigation of Communicable Disease

I.D. No. HLT-33-22-00002-E
Filing No. 612
Filing Date: 2022-07-28
Effective Date: 2022-07-28

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 2, section 405.3; addition of section 58-1.14 to Title 10 NYCRR.

Statutory authority: Public Health Law, sections 225, 576 and 2803

Finding of necessity for emergency rule: Preservation of public health.

Specific reasons underlying the finding of necessity: Where compliance with routine administrative procedures would be contrary to public interest, the State Administrative Procedure Act (SAPA) § 202(6) empowers state agencies to adopt emergency regulations necessary for the preservation of public health, safety, or general welfare. In this case, compliance with SAPA for filing of this regulation on a non-emergency basis, including the requirement for a period of time for public comment, cannot be met because to do so would be detrimental to the health and safety of the general public.

As stated in the declaration of the State disaster emergency in Executive Orders No. 11 through 11.8 (November 26, 2021, through August 13, 2022; see 9 NYCRR §§ 9.11 through 9.11.8), New York continues to experience high rates of COVID-19 transmission. The constant threat of a possible resurgence of COVID-19 or another communicable disease outbreak necessitates that the adoption of these regulatory amendments on an emergency basis. In addition, the emergency regulations also require clinical laboratories to report all test results, including negative and indeterminate results, for communicable diseases such as COVID-19; mandate hospitals to report syndromic surveillance data; and permit the Commissioner to direct hospitals to take patients during a disease outbreak such as COVID-19.