Subject: Digital Gaming Media Production Tax Credit Program.

Purpose: To create the administrative process for the program.

Substance of final rule: The regulation contained in 5 NYCRR Part 300 which governs the newly created Digital Gaming Media Production Tax Credit program is summarized as follows:

The regulation begins by noting that a digital gaming media production entity engaged in qualified digital gaming media production shall be allowed a 25% tax credit on qualified expenses for taxable years beginning on or after January 1, 2023 and before January 1, 2028. Furthermore, there is an additional 10% credit given for qualified digital gaming media production costs for a qualified digital gaming media production incurred and paid outside the metropolitan commuter transportation district in New York State.

In addition, the regulation clarifies that up to four million dollars in qualified digital gaming media production costs per production shall be used in the calculation of this credit and digital gaming media production costs may not include those costs used by the taxpayer or another taxpayer as the basis calculation of any other tax credit allowed under the Tax Law.

Next, the regulation lays out some key definitions including, but not limited to, "authorized applicant"; "certificate of conditional eligibility"; "certificate of tax credit"; "digital gaming media production costs" ; "diversity impact data"; "diversity plan"; "diversity report"; "qualified digital gaming media production"; "qualified digital gaming media production entity"; and "qualified digital gaming media production costs."

The regulation then addresses the application process which is bifurcated into an initial and final application phase. An authorized applicant shall submit an initial application to the Department prior to it paying or incurring digital gaming media production costs on a qualified digital gaming media production but no sooner than ninety (90) days before the start date of their qualified digital gaming media production. The Department then reviews the initial application to determine whether it meets the eligibility criteria set forth in the regulation. After this review, the Department will notify the authorized applicant of its eligibility.

Upon completion of the project, a final application must be submitted to the Department. The Department shall approve or disapprove the final application based upon criteria set forth in the regulation. If the final application is approved, the Department shall issue a certificate of tax credit to the approved applicant. Under no circumstances may a single taxpayer receive more than one million five hundred thousand dollars in tax credits per year. If the final application is disapproved, the Department shall provide the applicant with a notice of disapproval and such applicant may appeal the decision.

After clarifying that the aggregate amount of tax credits allowed under this program in any taxable year is $5 million, the regulation sets forth the criteria for evaluation of both initial and final applications. Such criteria contains requirements to submit both a diversity plan and diversity report to the Department as part of this application process.

Regarding record retention, the regulation states that applicants must maintain records, in paper or electronic form, of any qualified production costs used to calculate their potential or actual benefit(s) under this program for a minimum of three years from the date the applicant claims the tax credit.

The regulation next addresses an applicant's appeal process. It notes that if the authorized applicant's final application is disapproved by the Department, or if the approved applicant disagrees with the amount of the tax credit granted by the Department, the applicant has a right to appeal. Upon receipt of a timely letter of appeal, an independent hearing officer will be appointed by the Commissioner to handle the appeal. The independent hearing officer shall make a report on the appeal to the Commissioner. The Commissioner or designee shall issue a final order within 60 days of the report.

Finally, the regulation concludes with a section on exchange of information with Department of Taxation and Finance and reporting requirements.

The text of the rulemaking is available at: www.esd.ny.gov

Final rule as compared with last published rule: Nonsubstantive changes were made in section 300.2(j) and (m).

Text of rule and any required statements and analyses may be obtained from: Thomas Regan, Department of Economic Development, 625 Broadway, Albany, NY 12245, (518) 292-5110, email: thomas.regan@esd.ny.gov

Revised Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

As there have been no substantive changes to the last published rule, there are no changes to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement.

Initial Review of Rule

As a rule that does not require a RFA, RAFA or JIS, this rule will be initially reviewed in the calendar year 2025, which is no later than the 5th year after the year in which this rule is being adopted.

Assessment of Public Comment

The agency received no public comment.

Department of Financial Services

NOTICE OF ADOPTION

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-A
Filing No. 957
Filing Date: 2022-11-22
Effective Date: 2022-12-07

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

Action taken: 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; and Federal No Surprises Act

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

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

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

(d)(1) The disclosure requirements in Insurance Law sections 3217-a(a)(1) through (6), (9), (10), (15), (16), (17), (18), (19)(A) and (B), and (20); 3217-a(b)(1), (2), (4), (5), (7), (8) if applicable, (10), (11), (13) and (14); 4324(a)(1) through (6), (9), (10), (15), (16), (17), (19), (20)(A) and (B), and (21); and 4324-a(b)(1), (2), (4), (5), (7), (8) if applicable, (10), (11), (13) and (14) shall apply to stand-alone dental insurance and stand-alone vision insurance.

(2) In addition to the disclosure requirements in paragraph (1) of this subdivision, the disclosure requirements in Insurance Law section 3217-a(a)(7) and (11) through (13) and Insurance Law section 4324(a)(7) and (11) through (13) shall apply to stand-alone dental insurance and stand-alone vision insurance that meets the definition of a "managed care product" in Insurance Law section 4801(c).

(3) This subdivision shall apply to any policies issued, renewed, modified, or amended on or after one year after the effective date of this section.

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)(1) An issuer that issues comprehensive health insurance policies shall provide network status information to an insured in writing through print or electronic means, if the insured consents to electronic communication, within one business day of the insured requesting the information by telephone or through electronic means, if available.

(2) An issuer that issues a policy, other than a comprehensive health insurance policy, that uses a network of providers shall provide network status information to an insured in writing through print or electronic means, if the insured consents to electronic communication, within three business days of the insured requesting the information by telephone or through electronic means, if available.

(3) An issuer shall retain any recordings of telephone requests for network status information and a copy of its written response to the insured in the insured's file in accordance with section 243.2(b)(8) of this Part.

(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 or through electronic means, if available, that a non-participating provider is participating in the issuer's network;

(3) the issuer fails to provide information in writing through print or electronic means, if the insured consents to electronic communication, regarding a specific provider's participating status within the timeframes established in subdivision (c) of this section; 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 comprehensive health insurance policies issued, renewed, modified, or amended on or after the effective date of this section. This section shall apply to policies other than comprehensive health insurance policies that are issued, renewed, modified, or amended on or after one year after the effective date of this section.

Final rule as compared with last published rule: Nonsubstantial changes were made in sections 52.54(d), 52.77(c), (d) and (g).

Revised rule making(s) were previously published in the State Register on August 17, 2022.

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

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, 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 their issuer's provider directory, or request information before obtaining health care services, should not be responsible for unexpected bills when provided with inaccurate information. Furthermore, insureds covered by stand-alone dental or stand-alone vision insurance should have the same protections as insureds whose comprehensive health insurance policies include dental or vision benefits.

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 indicating a provider is in-network, through an online database, hard copy provider directory, or in response to the insured's request, or fails to provide network status information within one business day of an insured's request (collectively "inaccurate network status information"). The Federal Act 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 to an issuer on a timely basis. 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 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 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 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 regulation implements the requirements of Part AA and the Federal Act. It requires issuers to provide network status information to an insured upon request, in writing through print or electronic means if the insured consents to electronic communication, within one business day for comprehensive health insurance or three business days for other policies that use a network of providers. Electronic means includes email or Internet-based means, such as an online member portal. The regulation prohibits an issuer from imposing 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 when the issuer provides inaccurate network status information. 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 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 information. It also applies certain 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 regulation holds issuers responsible when they provide inaccurate network status information.

4. Costs: This regulation 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 regulation 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 benefits. Issuers that timely update their provider directories and timely provide accurate information in response to requests from insureds will not incur such costs; thus, the actual additional cost to an issuer will be dependent upon the issuer's timeliness and accuracy. However, any additional costs for comprehensive health insurance coverage are a result of the Federal Act and Part AA, and not this regulation, because this regulation implements the Federal Act and Part AA.

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

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

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

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

7. Duplication: This regulation 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 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 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 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 in relation to comprehensive health insurance coverage because the current requirements are consistent with the Federal Act. However, the Department did change the timeframe to three business days for stand-alone dental and vision coverage to address comments raised by interested parties.

The Department considered a request that the regulation 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 regulation only addresses issuer requirements.

9. Federal standards: The regulation 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 regulation for comprehensive health insurance 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. Issuers will need to comply with this regulation for any other applicable policies and contracts issued, renewed, modified, or amended on and after one year after the publication of the notice of adoption in the State Register.

Revised Regulatory Flexibility Analysis

1. Effect of rule: This regulation 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 regulation applies certain 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 nonparticipating provider is participating, or fails to provide information regarding a specific provider's participating status within one business day for comprehensive health insurance or three business days for other policies of a request from an insured. The regulation 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 regulation are small businesses. An issuer that may be a small business subject to the regulation 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 regulation implements the Federal Act and Part AA.

This regulation 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 regulation since the regulation 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 regulation, because the regulation implements the Federal Act and Part AA.

3. Professional services: No local government will need professional services to comply with this regulation because the regulation 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 regulation.

4. Compliance costs: No local government will incur any costs to comply with this regulation because the regulation 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 regulation 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 regulation implements the Federal Act and Part AA.

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

6. Minimizing adverse impact: There will not be an adverse impact on any local government because the regulation does not apply to any local government. This regulation should not have an adverse impact on an issuer that is a small business because the regulation 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 regulation, because this regulation 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 Procedure Act Section 202-b(6). Issuers that are small businesses also had an opportunity to participate in the rulemaking process when the proposed regulation was published in the State Register on November 24, 2021 and the revised proposed regulation was published in the State Register on August 17, 2022.

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 regulation 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 regulation 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 regulation, because the regulation 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 regulation.

3. Costs: This regulation 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 certain 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 regulation 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 regulation, because this regulation implements the Federal Act and Part AA.

4. Minimizing adverse impact: This regulation uniformly affects issuers that are located in both rural and non-rural areas of New York State. The regulation 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 regulation was published in the State Register on November 24, 2021 and the revised proposed regulation was published in the State Register on August 17, 2022.

Revised Job Impact Statement

The regulation implements the requirements of 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 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 regulation applies certain 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 regulation will reduce its workforce or vendor services due to this regulation, and therefore finds that this regulation should not have a substantial adverse impact on jobs or employment opportunities in New York State.

Initial Review of Rule

As a rule that requires a RFA, RAFA or JIS, this rule will be initially reviewed in the calendar year 2025, which is no later than the 3rd year after the year in which this rule is being adopted.

Assessment of Public Comment

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Principle-Based Reserving

I.D. No. DFS-49-22-00001-P

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

Proposed Action: This is a consensus rulemaking to amend Part 103 (Regulation 213) of Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 302; Insurance Law, sections 301, 4217 and 4517

Subject: Principle-Based Reserving.

Purpose: To adopt the 2022 Valuation Manual and amend the scope of section 103.4 to include certain group term life insurance.

Text of proposed rule: Footnote 1 to section 103.3(b) is amended as follows:

[1]The [2021] *2022* Valuation Manual, published by the National Association of Insurance Commissioners, is hereby incorporated by reference in this Part. The [2021] *2022* Valuation Manual is readily available without charge at the following internet address: https://www.naic.org/pbr_data.htm. The [2021] *2022* Valuation Manual is also available for public inspection and copying at the New York State Department of Financial Services, One State Street, New York, NY 10004.

The title of section 103.4 is amended as follows:

Valuation of individual term life insurance [reserves] *and individual certificates issued under a group term life contract*.

Section 103.4(a) is amended as follows:

(a) Scope. This section applies to all individual term life insurance policies *and all individual life certificates under a group term life contract that meet the requirements of section 1.B of VM-20,* whether directly written or assumed through reinsurance, issued on or after January 1, 2019.

Section 103.8(c)(1) is amended as follows:

(1) for individual term life insurance policies *and individual life certificates under a group term life contract* subject to section 103.4 of this Part, the greater of:

(i) the amount determined pursuant to section 103.4(c)(1) of this Part reduced by the credit for reinsurance determined pursuant to the Insurance Law and this Title, including Insurance Law section 1308, Part 79 (Insurance Regulation 133), Part 125 (Insurance Regulation 20), Part 126 (Insurance Regulation 114), Part 83 (Insurance Regulation 172), and Part 127 (Insurance Regulation 102) of this Title, and any other applicable regulations, as applicable; and

(ii) the minimum aggregate reserve after reflection of such reinsurance ceded calculated in accordance with the methodology and assumptions prescribed by the valuation manual;

Section 103.8(c)(3)(i) is amended as follows:

(i) the amount determined in section [103.6(b)(2)(i)(a)] *103.6(d)* or section [103.6(b)(3)(i)] *103.6(e)* of this Part, as applicable, reduced by the credit for reinsurance determined pursuant to the Insurance Law and this Title, including Insurance Law section 1308, Part 79 (Insurance Regulation 133), Part 125 (Insurance Regulation 20), Part 126 (Insurance Regulation 114), Part 83 (Insurance Regulation 172), and Part 127 (Insurance Regulation 102) of this Title, and any other applicable regulations, as applicable; and