

RULE MAKING ACTIVITIES

Each rule making is identified by an I.D. No., which consists of 13 characters. For example, the I.D. No. AAM-01-96-00001-E indicates the following:

AAM -the abbreviation to identify the adopting agency
01 -the *State Register* issue number
96 -the year
00001 -the Department of State number, assigned upon receipt of notice.
E -Emergency Rule Making—permanent action not intended (This character could also be: A for Adoption; P for Proposed Rule Making; RP for Revised Rule Making; EP for a combined Emergency and Proposed Rule Making; EA for an Emergency Rule Making that is permanent and does not expire 90 days after filing.)

Italics contained in text denote new material. Brackets indicate material to be deleted.

Department of Corrections and Community Supervision

NOTICE OF ADOPTION

Mount McGregor Correctional Facility

I.D. No. CCS-40-11-00002-A

Filing No. 1364

Filing Date: 2011-12-13

Effective Date: 2011-12-13

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

Action taken: Amendment of section 100.70 of Title 7 NYCRR.

Statutory authority: Correction Law, section 70

Subject: Mount McGregor Correctional Facility.

Purpose: To remove the reference to a correctional camp and an inmate program, both of which no longer operate at Mount McGregor Correctional Facility.

Text or summary was published in the October 5, 2011 issue of the Register, I.D. No. CCS-40-11-00002-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Maureen E. Boll, Deputy Commissioner and Counsel, NYS Department of Corrections and Community Supervision, The Harriman State Campus - Building 2, 1220 Washington Ave. - Albany, NY 12226-2050, (518) 457-4951, email: Rules@DOCCS.ny.gov

Assessment of Public Comment

The agency received no public comment.

Education Department

EMERGENCY RULE MAKING

Collaborative Drug Therapy Management

I.D. No. EDU-40-11-00001-E

Filing No. 1363

Filing Date: 2011-12-13

Effective Date: 2011-12-13

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

Action taken: Amendment of sections 63.7 and 63.10 of Title 8 NYCRR.

Statutory authority: Education Law, sections 207(not subdivided), 6504(not subdivided), 6507(2)(a), 6508(1), 6801-a, 6827(4); and L. 2011, ch. 21

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: The proposed amendment of section 63.7 and addition of section 63.10 of the Commissioner's regulations is necessary to conform the Commissioner's regulations to Chapter 21 of the Laws of 2011. The legislation was signed by the Governor on May 17, 2011, and adds a new section 6801-a of the Education Law authorizing the Collaborative Drug Management Therapy Demonstration Program for physicians and pharmacists working under the auspices of a teaching hospital. The new law, which sunsets three years from its effective date, restricts collaboration to pharmacists who meet specified education and experience requirements. In addition, the statute provides that pharmacists participating in CDTM complete five hours of relevant continuing education. The legislation authorizes the Commissioner to develop regulations necessary to implement the new law.

Consistent with the statute, the proposed amendment will add a new section 63.10 and amend section 63.7 of the Commissioner's Regulations to establish requirements necessary for implementation of Chapter 21 of the Laws of 2011. Because the Board of Regents meets at scheduled intervals, the earliest the proposed amendment could be presented for regular adoption, after publication of a Notice of Proposed Rule Making in the State Register and expiration of the 45-day public comment period prescribed in the State Administrative Procedure Act (SAPA), is at the December 12-13, 2011 meeting of the Board of Regents. If adopted at the December Regents meeting, the earliest the amendment could become effective pursuant to SAPA is December 28, 2011, the date of publication of the Notice of Adoption in the State Register. However, Chapter 21 of the Laws of 2011 takes effect on September 14, 2011, and directs that any rule or regulation necessary for the law's implementation be made and completed on or before such effective date.

Emergency action is necessary for the preservation of the public health and general welfare to immediately conform the Commissioner's regulations to Chapter 21 of the Laws of 2011, and thereby ensure that the Collaborative Drug Management Therapy Demonstration Program is implemented in a timely manner and consistent with statutory requirements.

Emergency action is also necessary to ensure that the emergency rule that was adopted at the September Regents meeting remains continuously in effect until it can be adopted as a permanent rule. The proposed rule was adopted as an emergency action at the September 2011 Regents meeting, effective September 14, 2011. A Notice of Proposed and Emergency Rule Making was published in the State Register on October 5, 2011. The September emergency rule will expire on December 12, 2011 and the per-

manent rule will not become effective until January 4, 2012. Therefore, emergency action is necessary to ensure that the emergency rule remains continuously in effect until such time as it can be adopted as a permanent rule.

Subject: Collaborative drug therapy management.

Purpose: Establish requirements to implement the Collaborative Drug Management Therapy Demonstration Program.

Text of emergency rule: 1. Subparagraph (i) of paragraph (2) of subdivision (b) of section 63.7 of the Regulations of the Commissioner of Education is amended, effective December 13, 2011, as follows:

(i) [Exemptions. The following licensees shall be exempt from the continuing education requirements, as prescribed in subdivision (c) of this section:

(a) licensees for the triennial registration period during which they are first licensed to practice pharmacy in New York State, exclusive of those first licensed to practice pharmacy in New York State pursuant to an endorsement of a license of another jurisdiction;

(b) licensees whose first registration date following January 1, 1997 occurs prior to January 1, 1998, for periods prior to such registration date; and

(c) licensees] *Exemption. Licensees* who are not engaged in the practice of pharmacy, as evidenced by not being registered to practice in New York State, *shall be exempt from the continuing education requirements, as prescribed in subdivision (c) of this section*, except as otherwise provided in paragraph (c)(2) of this section to meet the education requirements for the resumption of practice after a lapse in practice for a licensee who has not lawfully practiced continuously in another jurisdiction throughout such lapse period.

2. Paragraph (1) of subdivision (c) of section 63.7 of the Regulations of the Commissioner of Education is amended, effective December 13, 2011, as follows:

(1) During each triennial registration period, meaning a registration period of three years' duration, an applicant for registration shall complete at least 45 hours of formal continuing education acceptable to the department, as defined in paragraph (4) of this subdivision, provided that no more than 22 hours of such continuing education shall consist of self-study courses. During registration periods beginning on or after September 1, 2003, a licensee shall complete as part of the 45 hours of formal continuing education, or pro-rata thereof, at least three hours of formal continuing education acceptable to the department in the processes and strategies that may be used to reduce medication and/or prescription errors. *Any licensee participating in collaborative drug therapy management pursuant to Education Law section 6801-a, shall complete as part of the 45 hours of formal continuing education, or pro-rata thereof, at least five hours of formal continuing education acceptable to the department in the area or areas of practice generally related to any collaborative drug therapy management protocols to which the pharmacist may be subject, provided that such continuing education shall not be completed as self-study.* [Any licensed pharmacist whose first registration date following January 1, 1997 occurs less than three years from that date, but on or after January 1, 1998, shall complete continuing education hours on a prorated basis at the rate of one and one-quarter hours of acceptable formal continuing education per month for the period beginning January 1, 1997 up to the first registration date thereafter. Such continuing education shall be completed during the period beginning January 1, 1997 and ending before the first day of the new registration period or at the option of the licensee during any time in the previous registration period.]

3. Section 63.10 of the Regulations of the Commissioner of Education is added, effective December 13, 2011, to read as follows:

§ 63.10 Collaborative drug therapy management.

(a) *Applicability. This section shall apply only to the extent that the applicable provisions in Education Law sections 6801 and 6801-a, authorizing certain pharmacists to participate in collaborative drug therapy management, have not expired or been repealed.*

(b) *Experience requirement for participating pharmacists.*

(1) *As used in Education Law section 6801-a(2)(b), a year of experience shall mean not less than 1,680 hours of work as a pharmacist within a period of one calendar year.*

(2) *In order to be counted as a year of experience that includes clinical experience in a health facility, such experience shall include, on average, not less than 15 hours per week of clinical experience which involves consultation with physicians with respect to drug therapy, as determined by the facility that employs or is affiliated with the pharmacist.*

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt the provisions of this emergency rule as a permanent rule, having previously submitted to the Department of State a notice of proposed rule making, I.D. No. EDU-40-11-00001-EP, Issue of October 5, 2011. The emergency rule will expire February 10, 2012.

Text of rule and any required statements and analyses may be obtained from: Mary Gammon, New York State Education Department, 89 Washington Avenue, Room 138, Albany, New York 12234, (518) 473-8296, email: legal@mail.nysed.gov

Regulatory Impact Statement

1. STATUTORY AUTHORITY:

Section 207 of the Education Law grants general rule-making authority to the Board of Regents to carry into effect the laws and policies of the State relating to education.

Section 6504 of the Education Law authorizes the Board of Regents to supervise the admission to and regulation of the practice of the professions.

Subparagraph (a) of subdivision (2) of section 6507 of the Education Law authorizes the Commissioner to promulgate regulations in administering the admission to the practice of the professions.

Subdivision (1) of section 6508 of the Education Law provides that state boards for the professions shall assist the Board of Regents and Department on matters of professional licensing.

Section 6801-a of the Education Law establishes the Collaborative Drug Therapy Management (CDTM) Demonstration Program.

Subdivision (4) of section 6827 of the Education Law authorizes the Commissioner of Education to promulgate regulations setting standards for coursework that may be used to satisfy continuing education requirements for pharmacists.

Section (5) of chapter 21 of the Laws of 2011 authorizes and directs the promulgation of any rule necessary for the implementation of the CDTM demonstration program.

2. LEGISLATIVE OBJECTIVES:

On May 17, 2011 Governor Cuomo signed into law Chapter 21 of the Laws of 2011, which added a new section 6801-a of the Education Law authorizing the Collaborative Drug Therapy Management (CDTM) Demonstration Program for physicians and pharmacists working under the auspices of a teaching hospital. The new law, which sunsets three years from its effective date, restricts collaboration to pharmacists who meet specified education and experience requirements. In addition, the statute provides that pharmacists participating in CDTM complete five hours of relevant continuing education, and requires the Department, in consultation with the Department of Health, to prepare a report to the legislature on the implementation of the CDTM. The report will review the extent to which CDTM was implemented, and will examine whether, and the extent to which, it contributed to improvement of quality of care for patients, reduced the risk of medication error, reduced unnecessary health care expenditures, and was otherwise in the public interest.

The legislation authorizes the Department to develop regulations necessary to implement the new law. The proposed rule establishes standards for the experience required for a pharmacist to participate in CDTM, and revises continuing education requirements to reflect the new statutory provisions for pharmacists engaging in CDTM.

Concurrently, the proposed rule updates the continuing education regulations for pharmacists by deleting out-dated references.

3. NEEDS AND BENEFITS:

The proposed rule is necessary to implement Chapter 21 of the Laws of 2011, which establishes the Collaborative Drug Therapy Management (CDTM) Demonstration Program.

To date, 46 other states have already authorized collaboration between medication prescribers and pharmacists for the purpose of improving therapeutic outcomes from medication therapies. The purpose of such collaboration is to reduce morbidity and mortality, reduce emergency room visits and hospital admissions, and otherwise reduce health care spending. Included among the many disease states in which such improvements have been documented are asthma, diabetes, and clotting disorders or other indications for anticoagulation.

4. COSTS:

(a) **Costs to State government:** The proposed rule is necessary to implement Chapter 21 of the Laws of 2011 and imposes no additional costs on State government, other than those inherent in the statute.

(b) **Costs to local government:** The proposed rule relates solely to the requirement for licensees engaged in the practice of pharmacy and does not impose any costs on local government.

(c) **Cost to private regulated parties:** The proposed rule will not increase costs, and may provide cost-savings to regulated parties, patients, institutions and patients. Therefore, there will be no additional costs to private regulated parties.

(d) **Costs to the regulatory agency for implementation and continued administration of the rule:** The proposed rule imposes no additional costs on the State Education Department, other than those inherent in the statute.

5. LOCAL GOVERNMENT MANDATES:

The proposed rule relates solely to the requirement for licensees engaged in the practice of pharmacy and does not impose any programs, service, duty, or responsibility upon local governments.

6. PAPERWORK:

The proposed rule imposes no new reporting requirements.

7. DUPLICATION:

The proposed rule does not duplicate other existing state or federal requirements.

8. ALTERNATIVES:

The proposed rule is necessary to implement Chapter 21 of the Laws of 2011, which establishes the Collaborative Drug Therapy Management (CDTM) demonstration program. There are no viable alternatives to the proposed rule and none were considered.

9. FEDERAL STANDARDS:

Federal standards do not apply, nor does the proposed rule exceed federal standards.

10. COMPLIANCE SCHEDULE:

Consistent with the statute, the proposed rule would become effective on September 14, 2011, at which time licensees and participating facilities must comply with the proposed amendments if engaged in Collaborative Drug Therapy Management. Participation in CDTM is voluntary and it is anticipated that regulated parties will be able to comply with the rule's provisions by its effective date.

Regulatory Flexibility Analysis

The proposed rule is necessary to implement the Collaborative Drug Therapy Management (CDTM) demonstration program pursuant to Chapter 21 of the Laws of 2011, and relates to the practice of pharmacy, defining who and under what conditions certain pharmacists may engage in collaborative drug therapy management with physician prescribers of medications. The proposed rule also revises the continuing education requirements for pharmacists to conform with the CDTM demonstration program and to delete certain outdated provisions. The proposed rule will not impose any reporting, recordkeeping, or other compliance requirements, or any adverse economic impact, on small businesses or local governments. Because it is evident from the nature of the proposed rule that it will not affect small businesses or local governments, no affirmative steps were needed to ascertain that fact and none were taken. Accordingly, a regulatory flexibility analysis for small businesses and local governments is not required and one has not been prepared.

Rural Area Flexibility Analysis

1. TYPES AND ESTIMATED NUMBER OF RURAL AREAS:

The rule will apply to the 44 rural counties with less than 200,000 inhabitants and the 71 towns in urban counties with a population density of 150 per square mile or less. Of the 22,344 pharmacists registered by the State Education Department, 2,821 pharmacists report their permanent address of record is in a rural county.

2. REPORTING, RECORDKEEPING AND OTHER COMPLIANCE REQUIREMENTS; AND PROFESSIONAL SERVICES:

The proposed rule is necessary to implement Chapter 21 of the Laws of 2011, which establishes the Collaborative Drug Therapy Management (CDTM) Demonstration Program. The proposed rule's provisions allow certain pharmacists, practicing within teaching hospitals, to engage in CDTM with physician prescribers of medications. The proposed rule will also delete continuing education provisions that are no longer applicable. The proposed rule will not impose reporting, recordkeeping, or other compliance requirements and will not require the use of additional professional services.

3. COSTS:

The proposed rule is necessary to implement Chapter 21 of the Laws of 2011 and does not impose any additional costs on regulated parties. The proposed rule will not increase costs, and may provide cost-savings to regulated parties, patients, institutions and patients.

4. MINIMIZING ADVERSE IMPACT:

Following discussions, including obtaining input from practicing professionals, the State Board of Pharmacy has considered the terms of the proposed amendments to Regulations of the Commissioner of Education and has recommended the changes. Additionally, the measures have been shared with educational institutions, professional associations, and practitioners representing the profession of pharmacy. The amendments are supported by representatives of these sectors. The proposals make no exception for individuals who live in rural areas. The Department has determined that such requirements should apply to all pharmacists and pharmacies State-wide and regardless of their geographic location, to ensure a uniform standard of practice across the State. Accordingly, it is neither appropriate nor warranted to establish different requirements for entities located in rural areas.

5. RURAL AREA PARTICIPATION:

Comments on the proposed rule were solicited from Statewide organizations representing all parties having an interest in the practice of pharmacy. Included in this group were members of the State Board of Pharmacy, educational institutions, and professional associations representing the pharmacy profession, such as the Pharmacists Society of the State of New York and the New York State Council of Health System Pharmacists. These groups, which have representation in rural areas, have been provided notice of the proposed rule making and opportunity to comment on the regulations.

Job Impact Statement

The proposed rule is necessary to implement the Collaborative Drug Therapy Management (CDTM) demonstration program pursuant to Chapter 21 of the Laws of 2011, and relates to the practice of pharmacy, defining who and under what conditions certain pharmacists may engage in CDTM with physician prescribers of medications. The proposed rule also revises the continuing education requirements for pharmacists to conform with the CDTM demonstration program and to delete certain outdated provisions. The proposed rule will not adversely impact jobs and employment opportunities. Because it is evident from the nature of the proposed rule that it will not affect job and employment opportunities, no affirmative steps were needed to ascertain that fact and none were taken. Accordingly, a job impact statement is not required and one has not been prepared.

Department of Environmental Conservation

NOTICE OF ADOPTION

Otter Creek Trail System Assembly Area

I.D. No. ENV-22-11-00003-A

Filing No. 1335

Filing Date: 2011-12-09

Effective Date: 2011-12-28

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

Action taken: Addition of section 190.32 to Title 6 NYCRR.

Statutory authority: Environmental Conservation Law, sections 1-0101(1), (3)(b), 3-0301(1), (1)(b), (2)(m), 9-0105(1) and (3)

Subject: Otter Creek Trail System Assembly Area.

Purpose: To protect natural resources and public safety.

Text or summary was published in the June 1, 2011 issue of the Register, I.D. No. ENV-22-11-00003-P.

Final rule as compared with last published rule: No changes.

Revised rule making(s) were previously published in the State Register on October 19, 2011.

Text of rule and any required statements and analyses may be obtained from: Robert Messenger, Bureau Chief, State Land Management, NYS DEC, 625 Broadway, Albany, New York 12233, (518) 402-9428, email: rjmessen@gw.dec.state.ny.us

Additional matter required by statute: A Negative Declaration has been prepared in compliance with Article 8 of the Environmental Conservation Law.

Assessment of Public Comment

The agency received no public comment.

Department of Financial Services

EMERGENCY RULE MAKING

Limitation of New Enrollment to the Healthy NY High Deductible Plan Pursuant to Section 4326(g) of the Insurance Law

I.D. No. DFS-52-11-00002-E

Filing No. 1332

Filing Date: 2011-12-07

Effective Date: 2011-12-07

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

Action taken: Addition of section 362-2.9 (Regulation 171) to Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301, and 302; and Insurance Law, sections 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305, 4326 and 4327

Finding of necessity for emergency rule: Preservation of public health and general welfare.

Specific reasons underlying the finding of necessity: Chapter 1 of the Laws of 1999 enacted the Healthy New York ("Healthy NY") program, an initiative designed to enable small employers to provide health insurance to employees and their families and to provide working uninsured individuals with an affordable health insurance coverage option. The program offers standard benefit packages and high deductible health plan options to eligible individuals and employers. Healthy NY currently provides essential health coverage to over 170,000 New Yorkers.

Due to State fiscal constraints, the New York State budget has set Healthy NY funding appropriations at approximately \$160 million for the past three consecutive fiscal years. During this timeframe, Healthy NY enrollment and claims have increased. As a result, there has been a need to pro-rate stop loss distributions to health plans for the last two years.

Health maintenance organizations and participating insurers ("health plans") are currently setting Healthy NY premiums for 2012. In developing proposed premium rates for 2012, most health plans have assumed that future funding for Healthy NY will again be held flat. This has caused health plans to apply for significant rate increases, to the detriment of Healthy NY's low income enrollees and applicants.

In response to the anticipated rate increases, the Department of Financial Services proposes to promulgate this amendment to 11 NYCRR Part 362. Through this amendment, existing Healthy NY enrollees will be permitted to keep their current coverage option. New applicants, for coverage effective January 1, 2012 or later, will be limited to Healthy NY's high deductible health plans only. This change will allow the Department to better leverage the program's limited financial resources because Healthy NY high deductible health plans are not as popular with consumers as the standard Healthy NY products. Therefore, we expect new enrollment in the program to decrease. This decrease, combined with normal program attrition, will lead to an overall reduction in the size of the Program. State stop loss funds will go further in providing premium support to this smaller population.

The Department recognizes that this change will pose a hardship for some applicants seeking broader choice in benefit options. However, the Department believes this approach strikes a balance in protecting existing enrollees from unaffordable rate increases, while maintaining an affordable option for those purchasing coverage.

This emergency filing is necessary at this time in order to ensure that the health plans have adequate time to prepare for this change to the program. The plans will need to educate their customer service personnel regarding the new enrollment restrictions, make revisions to websites and consumer materials, and notify brokers about the enrollment restrictions. If the health plans are fully prepared to implement this change, eligible applicants who wish to enroll in the Healthy NY high deductible option effective January 1, 2012 and thereafter will be able to do so without any impediments.

In light of the foregoing, it is critical that this amendment be adopted as promptly as possible, and this rule must be promulgated on an emergency basis for the furtherance of the public health and general welfare.

Subject: Limitation of new enrollment to the Healthy NY high deductible plan pursuant to Section 4326(g) of the Insurance Law.

Purpose: To mitigate large premium increases for current enrollees in Healthy NY by limiting new enrollees to the high deductible plan.

Text of emergency rule: A new section 362-2.9 is added to read as follows:

§ 362-2.9 *Healthy New York Enrollment Limitation*

(a) *With respect to coverage effective on or after January 1, 2012, a health maintenance organization or a participating insurer may enroll new applicants in the Healthy New York Program only in the high deductible health plans set forth in section 362-2.8 of this Part.*

(b) *With respect to existing enrollees who are in non-high deductible health plans with coverage effective prior to January 1, 2012, a health maintenance organization or a participating insurer shall:*

(1) *permit qualifying individuals to add dependents to or remove dependents from their qualifying health insurance contracts; and*

(2) *permit qualifying small employers to add employees and dependents to or remove employees and dependents from their qualifying health insurance contracts.*

(c) *A health maintenance organization or participating insurer shall permit qualifying individuals and qualifying employers enrolled in non-high deductible plans to change their benefit packages to other non-high deductible plans with the same health maintenance organization or*

participating insurer at the time of annual recertification or a change in the premium rate.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire March 5, 2012.

Text of rule and any required statements and analyses may be obtained from: Patricia Patwell, Department of Financial Services, One Commerce Plaza, Albany, NY 12257, (518) 486-7815, email: Patricia.Patwell@dfs.ny.gov

Regulatory Impact Statement

1. **Statutory authority:** The Superintendent's authority for the adoption of the fourth amendment to 11 NYCRR 362 is derived from sections 202, 301, and 302 of the Financial Services Law ("FSL") and sections 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305, 4326, and 4327 of the Insurance Law.

Section 202 of the Financial Services Law establishes the office of the Superintendent and designates the Superintendent to be the head of the Department of Financial Services.

FSL section 301 establishes the powers of the Superintendent generally. FSL section 302 and section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to the Superintendent by the Insurance Law, the Banking Law, the Financial Services Law, or any other law of this state and to prescribe regulations interpreting the Insurance Law.

Section 1109 of the Insurance Law authorizes the Superintendent to promulgate regulations in effectuating the purposes and provisions of the Insurance Law and Article 44 of the Public Health Law with respect to the contracts between a health maintenance organization (HMO) and its subscribers.

Section 3201 of the Insurance Law authorizes the Superintendent to approve accident and health insurance policy forms for delivery or issuance for delivery in this state.

Section 3216 of the Insurance Law sets forth the standard provisions to be included in individual accident and health insurance policies written by commercial insurers.

Section 3217 of the Insurance Law authorizes the Superintendent to issue regulations to establish minimum standards, including standards of full and fair disclosure, for the form, content and sale of accident and health insurance policies.

Section 3221 of the Insurance Law sets forth the standard provisions to be included in group or blanket accident and health insurance policies written by commercial insurers.

Section 4235 of the Insurance Law defines group accident and health insurance and the types of groups to which such insurance may be issued.

Section 4303 of the Insurance Law governs the accident and health insurance contracts written by non-for-profit corporations and sets forth the benefits that must be covered under such contracts.

Section 4304 of the Insurance Law includes requirements for individual health insurance contracts written by not-for-profit corporations and HMOs.

Section 4305 includes requirements for group health insurance contracts written by not-for-profit corporations and HMOs.

Section 4326 of the Insurance Law authorizes the creation of a program to provide standardized health insurance to qualifying small employers and qualifying working uninsured individuals. Section 4326(g) authorizes the Superintendent to modify the copayment and deductible amounts for qualifying health insurance contracts. Section 4326(g) also authorizes the Superintendent to establish additional standardized health insurance benefit packages to meet the needs of the public after January 1, 2002.

Section 4327 of the Insurance Law authorizes the establishment of stop loss funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals. Section 4327(k) authorizes the suspension of enrollment in the program if it is anticipated that annual expenditures from the stop loss fund will exceed the total funds available for distribution from the fund.

2. **Legislative objectives:** Chapter 1 of the Laws of 1999 enacted the Healthy New York (Healthy NY) program, an initiative designed to enable small employers to provide health insurance to employees and their families and to provide working uninsured individuals with an affordable health insurance coverage option.

3. **Needs and benefits:** Healthy NY provides essential health coverage to over 170,000 New Yorkers. Due to State fiscal constraints, the New York State budget set Healthy NY funding appropriations at approximately \$160 million for the past three consecutive fiscal years. During this timeframe, Healthy NY enrollment and claims increased. As a result, there has been a need to pro-rate state payments to health plans for the last two years. This has caused health plans to apply for significant rate increases, to the detriment of Healthy NY's low income enrollees and applicants.

In response, the Department of Financial Services intends to better utilize Healthy NY's limited financial resources. Expedited promulgation of this regulation is the first and most necessary step to better utilizing program resources. This rule will permit existing Healthy NY enrollees to keep their current coverage option. New applicants, for coverage effective January 1, 2012 or later, will be limited to Healthy NY's high deductible health plans only. The Department believes this approach strikes a balance in protecting existing enrollees from unaffordable rate increases, while maintaining an affordable option for those purchasing coverage.

Healthy NY high deductible health plans are not as popular with consumers as the standard Healthy NY products. Therefore, we expect new enrollment in the program to decrease. This decrease, combined with normal program attrition, will lead to an overall reduction in the size of the program. State stop loss funds will go further in providing premium support to this smaller population. As noted above, expedited promulgation of this regulation is necessary to begin the limitation of program enrollment that will ultimately lead to more effective usage of the stop loss funds.

4. **Costs:** This rule imposes no compliance costs upon state or local governments. The overall costs of the program are capped at the appropriated funding amounts. Through this rule the Department of Financial Services expects to be able to maintain the viability of the program within the appropriated funding amounts.

5. **Local government mandates:** This rule imposes no new mandates on any county, city, town, village, school district, fire district or other special district.

6. **Paperwork:** Healthy NY requires HMOs and participating insurers to report enrollment changes on a monthly basis and also requires an annual request for reimbursement of eligible claims. Twice a year, enrollment reports that discern enrollment on a county-by-county basis are submitted to the Department. This rule will not impose any new reporting requirements.

7. **Duplication:** There are no known federal or other states' requirements that duplicate, overlap, or conflict with this regulation.

8. **Alternatives:** The Department of Financial Services examined multiple alternatives ranging from full program suspension to adjustments to benefits and cost-sharing amounts. It was determined that a full program suspension would have eliminated an affordable health insurance alternative for the working uninsured, and adjustments to benefits and cost-sharing would have had an insufficient impact on savings. Thus, it was decided that this rule would have the most positive outcome in that it will strike a balance in protecting existing enrollees from unaffordable rate increases, while maintaining an affordable option for those who seek to purchase coverage.

9. **Federal standards:** The Healthy NY high deductible health plans meet all federal standards to ensure that program enrollees achieve any available federal tax benefits.

10. **Compliance schedule:** HMOs and participating insurers are required to comply immediately.

Regulatory Flexibility Analysis

1. **Effect of rule:** This rule will affect small businesses that are seeking to enter the Healthy New York (Healthy NY) program because it will limit the number of Healthy NY coverage options that they can offer to their employees. However, the Department of Financial Services feels that qualifying small businesses that choose to offer the high deductible health plan option to their employees will be able to attract and keep talented workers. This rule will have the greatest impact upon health maintenance organizations (HMOs) and licensed insurers in New York State, none of which fall within the definition of small business as found in section 102(8) of the State Administrative Procedure Act. This rule will not affect local governments.

2. **Compliance requirements:** There are no compliance requirements for small businesses or local governments. As noted above, this rule will have the greatest impact upon HMOs and licensed insurers in New York State, none of which fall within the definition of small business as found in section 102(8) of the State Administrative Procedure Act.

3. **Professional services:** No professional services will be necessitated as a result of this rule.

4. **Compliance costs:** This rule should reduce insurance costs for qualifying small businesses that choose to offer the high deductible health plan to their employees. This rule imposes no compliance costs to local governments.

5. **Economic and technological feasibility:** The Healthy NY program is designed to make health insurance premiums more affordable for small businesses. Compliance with this rule should be economically and technologically feasible as it requires no action on their part.

6. **Minimizing adverse impact:** This rule minimizes the impact on small businesses by providing an affordable health insurance option that the businesses can choose to offer to their employees.

7. **Small business and local government participation:** This notice is

intended to provide small businesses, local governments and public and private entities in rural and non-rural areas with an additional opportunity to participate in the rule-making process.

Rural Area Flexibility Analysis

1. **Types and estimated numbers of rural areas:** Health maintenance organizations (HMOs) and participating insurers to which this regulation is applicable do business in every county of the State, including rural areas as defined under section 102(10) of the State Administrative Procedure Act. Small employers and individuals in need of health insurance coverage are located in every county of the State, including rural areas as defined under section 102(10) of the State Administrative Procedure Act.

2. **Reporting, recordkeeping and other compliance requirements;** and professional services: Healthy New York requires HMOs and participating insurers to report enrollment changes on a monthly basis and also requires an annual request for reimbursement of eligible claims. Twice a year, enrollment reports that discern enrollment on a county by county basis are submitted to the Department of Financial Services. This rule will not add any new reporting requirements, though it will require separate identification of enrollment in the high deductible health plan option. Nothing in this rule distinguishes between rural and non-rural areas. No special type of professional services will be needed in a rural area to comply with this requirement.

3. **Costs:** HMOs and participating insurers may incur some minor costs as they educate their customer service staff on the changes being made to the program. There are no costs to local governments. This rule has no impact unique to rural areas.

4. **Minimizing adverse impact:** Because the same requirements apply to both rural and non-rural entities, the rule will have the same impact on all affected entities.

5. **Rural area participation:** None.

Job Impact Statement

While this rule may reduce the number of health coverage options available to employees; it will not adversely affect jobs or employment opportunities. A health maintenance organization or a participating insurer shall continue to permit existing Healthy New York (Healthy NY) enrollees to keep their current coverage option. New applicants, for coverage effective January 1, 2012 or later, will be limited to Healthy NY's high deductible health plans only. The Department believes that this approach strikes a balance in protecting existing enrollees from unaffordable rate increases, while maintaining an affordable option for those purchasing new coverage. It is the Department's position that this rule will permit employers enrolled in the program to maintain health insurance coverage for their employees. The ability to offer affordable coverage will allow employers to attract and retain qualified workers. Through this rule the Department of Financial Services intends to better leverage Healthy NY's limited financial resources.

EMERGENCY RULE MAKING

Workers' Compensation Insurance

I.D. No. DFS-52-11-00003-E

Filing No. 1333

Filing Date: 2011-12-07

Effective Date: 2011-12-07

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

Action taken: Addition of Subpart 151-6 (Regulation 119) to Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301 and 302; Insurance Law, section 301; and Workers' Compensation Law, sections 15(8)(h)(4) and 151(2)(b)

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the Workers' Compensation Board ("WCB") to assess insurers and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' WCB, respectively. The assessments are allocated to insurers, self-insurers, group self-insurers, and the State Insurance Fund based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, the insurer pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

Prior to January 1, 2010, the Workers' Compensation Law required the

Workers' Compensation Board to assess insurers on the total "direct premiums" they wrote in the preceding calendar year, whereas the insurers were collecting the assessments from their insureds on the basis of "standard premium," which took into account high deductible policies. As high deductible policies increased in the marketplace, a discrepancy developed between the assessment an insurer collected, and the assessment the insured was required to remit to the Workers' Compensation Board.

Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the WCB collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" in order to ensure that insurers are not overcharged or under-charged for the assessment, and to ensure that insureds with high deductible policies are charged the appropriate assessment. Effective January 1, 2010, therefore, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the Superintendent of Insurance to define "standard premium," for the purposes of setting the assessments, and to set rules, in consultation with the WCB, and New York Compensation Rating Board, for collecting the assessment from insureds.

This regulation was previously promulgated on an emergency basis on December 29, 2009, March 25, 2010, June 24, 2010, September 20, 2010, December 18, 2010, March 18, 2011, June 13, 2011, and September 9, 2011. The Department is awaiting approval to publish the regulation, however because the effective date of the relevant provision of the law is January 1, 2010, and the need that the assessments be calculated and collected in a timely manner, it is essential that this regulation, which establishes procedures that implement provisions of the law, be continued on an emergency basis.

For the reasons cited above, this regulation is being promulgated on an emergency basis for the benefit of the general welfare.

Subject: Workers' Compensation Insurance.

Purpose: This regulation is necessary to standardize the basis upon which the workers' compensation assessments are calculated.

Text of emergency rule: A new sub-part 151-6 entitled Workers' Compensation Insurance Assessments is added to read as follows:

Section 151-6.0 Preamble

(a) Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the Workers Compensation Board to assess insurers, and the State Insurance Fund for the special disability fund, the fund for reopened cases, and the operations of the Board, respectively. First, the assessments are allocated to insurers, self-insurers, group self-insurers, and SIF based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, each pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

(b) Prior to January 1, 2010, each insurer paid a percentage of the allocation based on the total direct written premiums it wrote in the preceding calendar year. However, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the Board collects the portion of the allocation from each insurer. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the superintendent of insurance (the "superintendent") to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the Board and NYCIRB for collecting the assessment from insureds.

Section 151-6.1 Definitions

As used in this Part:

- (a) Board means the New York Workers Compensation Board.
- (b) Insurer means an insurer authorized to write workers' compensation insurance in this state, except for the SIF.
- (c) NYCIRB means the New York Workers Compensation Rating Board.
- (d) SIF means the State Insurance Fund.
- (e) Standard premium means
 - (i) the premium determined on the basis of the insurer's approved rates; as modified by:
 - (a) any experience modification or merit rating factor;
 - (b) any applicable territory differential premium;
 - (c) the minimum premium;
 - (d) any Construction Classification Premium Adjustment Program credits;
 - (e) any credit from return to work and/or drug and alcohol prevention programs;
 - (f) any surcharge or credit from a workplace safety program;
 - (g) any credit from independently-filed insurer specialty programs (for example, alternative dispute resolution, drug-free workplace, managed care or preferred provider organization programs);

- (h) any charge for the waiver of subrogation;
- (i) any charge for foreign voluntary coverage; and
- (j) any additional charges for terrorism, and the charge for natural disasters and catastrophic industrial accidents.

(ii) For purposes of determining standard premium, the insurer's expense constant, including the expense constant in the minimum premium, the insurer's premium discount, and premium credits for participation in any deductible program shall be excluded from the premium base.

(iii) The insurer shall use the definition of standard premium set forth in this Part to report standard premium to the Board.

Section 151-6.2 Collection of assessments

Any assessments required by Workers' Compensation Law sections 15(8)(h)(4), 25-A(3) and 151(2)(b) that are collected by an insurer or SIF from policyholders shall be collected through a surcharge based on standard premium in a percentage to be determined by the superintendent in consultation with NYCIRB and the Board.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire March 5, 2012.

Text of rule and any required statements and analyses may be obtained from: David Neustadt, Department of Financial Services, One State Street, New York, NY 10004-1511, (212) 709-1691, email: david.neustadt@dfs.ny.gov

Regulatory Impact Statement

1. Statutory authority: The authority of the Superintendent of Financial Services for the promulgation of Part 151-6 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Fifth Amendment to Regulation No. 119) derives from Sections 202, 301, and 302 of the Financial Services Law ("FSL"), Section 301 of the Insurance Law, and Sections 15, 25-A, and 151 of the Workers' Compensation Law.

FSL section 301 establishes the powers of the Superintendent generally. FSL section 302 and section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to the Superintendent by the Insurance Law, the Banking Law, the Financial Services Law, or any other law of this state and to prescribe regulations interpreting the Insurance Law.

Sections 15, 25-A, and 151 of the Workers' Compensation Law, as amended by Part QQ of Chapter 56 of the Laws of 2009 require the Superintendent to define the "standard premium" upon which assessments are made for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' Compensation Board ("WCB"). Section 15 of the Workers' Compensation Law further requires workers' compensation insurers to collect the assessments from their policyholders through a surcharge based on premiums in accordance with the rules set forth by the Superintendent, in consultation with the New York Workers' Compensation Insurance Rating Board ("NYCIRB"), and the chair of the WCB.

2. Legislative objectives: (a) Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the WCB to assess insurers writing workers' compensation insurance and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the WCB, respectively. The assessments are allocated to insurers, self-insurers, group self-insurers, and the State Insurance Fund based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, the insurer pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

Prior to January 1, 2010, the Workers' Compensation Law required the WCB to assess insurers based on the total "direct premiums" they wrote in the preceding calendar year, whereas the insurers collected assessments from their insureds based on the "standard premium," which took into account high deductible policies. As high deductible policies increased in the marketplace, a discrepancy developed between the assessment an insurer collected and the assessment the insurer was required to remit to the WCB.

Therefore, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the Board collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" to ensure that insurers are not overcharged or under-charged for the assessment, and to make certain that insureds with high deductible policies are charged the appropriate assessment. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the Superintendent to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting assessments from insureds.

3. Needs and benefits: This amendment is necessary, and mandated by

the Workers' Compensation Law, to standardize the basis upon which the workers' compensation assessments are calculated to eliminate any discrepancy between the amount that an insurer collects from employers and the amount that an insurer remits to the WCB.

The discrepancy in the assessment calculation and remittance became evident as a result of the proliferation of large deductible policies. In many instances, the "direct premium" paid on a large deductible policy is less than the "standard premium" would be for that policy. Insurers that offered high-deductible policies collected assessments based on the "standard premium," but the Workers' Compensation Law required the WCB to use "direct premiums" to bill insurers. Thus, in some instances, workers' compensation insurers collected from employers more money than they remitted to the WCB.

4. Costs: This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amendment itself does not impose new costs, the impact of changing the basis for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

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

6. Paperwork: This amendment requires no new paperwork. Insurers and the State Insurance Fund already collect and remit assessments to the WCB. This regulation only standardizes the basis upon which the assessments are calculated, as required by the Workers' Compensation Law.

7. Duplication: The amendment will not duplicate any existing state or federal rule.

8. Alternatives: No alternatives were considered, because Part QQ requires the Superintendent to define "standard premium" for the purpose of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting the assessment from insureds. Based on discussions with NYCIRB and the WCB, the Superintendent determined that the term "standard premium" should conform to the definition currently used by insurers, and should ensure that the definition accounts for high deductible policies.

NYCIRB has been collecting premium data on a "standard" basis since its inception nearly 100 years ago. The "standard premium" is the premium without regard to credits, deviations, or deductibles. As new credits and types of policies (such as large deductible policies) develop, NYCIRB adjusts the definition to account for the changes. The Department of Financial Services is merely adopting NYCIRB's current definition.

9. Federal standards: There are no applicable federal standards.

10. Compliance schedule: The effective date of the relevant provision of the law is January 1, 2010. The assessments must be calculated and collected as of January 1, 2010.

Regulatory Flexibility Analysis

1. Small businesses:

The Department of Financial Services finds that this rule will not impose any adverse economic impact on small businesses and will not impose any reporting, recordkeeping or other compliance requirements on small businesses.

This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as to the State Insurance Fund ("SIF"). It standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board.

The basis for this finding is that this rule is directed at workers' compensation insurers authorized to do business in New York State, none of which falls within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act. The Department of Financial Services has monitored Annual Statements and Reports on Examination of authorized workers' compensation insurers subject to this rule, and believes that none of the insurers falls within the definition of "small business," because there are none that are both independently owned and have fewer than one hundred employees. Nor does SIF come within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act, because SIF is neither independently owned nor operated, and does not employ one hundred or fewer individuals.

2. Local governments:

The amendment does not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements on any local governments. This amendment does not affect self-insured local governments, because it applies only to insurers.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as the State Insurance Fund ("SIF"). These entities do business throughout New York State, including rural areas as defined in section 102(10) of the State Administrative Procedure Act ("SAPA").

2. Reporting, recordkeeping and other compliance requirements, and professional services: This regulation is not expected to impose any reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. Insurers and SIF already collect and remit assessments to the Workers' Compensation Board ("WCB"). This amendment simply standardizes the basis upon which the assessments are calculated.

3. Costs: This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amendment itself does not impose new costs, the impact of changing the basis for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

4. Minimizing adverse impact: The amendment does not impose any impact unique to rural areas.

5. Rural area participation: This amendment is required by statute. The entities covered by this amendment - workers' compensation insurers authorized to do business in New York State and the State Insurance Fund - do business in every county in this state, including rural areas as defined in section 102(10) of SAPA. This amendment standardizes the basis upon which the workers' compensation assessments are calculated.

Job Impact Statement

This rule will not adversely impact job or employment opportunities in New York. The rule merely standardizes the basis upon which workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board. An insurer's existing personnel should be able to perform this task. There should be no region in New York that would experience an adverse impact on jobs and employment opportunities. This rule should not have a measurable impact on self-employment opportunities.

NOTICE OF ADOPTION

State Charter Advisory Board ("Board"): Selection of Candidates Representing Banking Institutions

I.D. No. DFS-42-11-00012-A

Filing No. 1338

Filing Date: 2011-12-12

Effective Date: 2011-12-28

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

Action taken: Addition of Part 600 to Title 23 NYCRR.

Statutory authority: L. 2011, ch. 62, part A, section 205-b

Subject: State Charter Advisory Board ("Board"); selection of candidates representing banking institutions.

Purpose: This rule implements Section 205-b by providing a mechanism to nominate, select, and appoint Board members.

Text or summary was published in the October 19, 2011 issue of the Register, I.D. No. DFS-42-11-00012-EP.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Sam L. Abram, Assistant Counsel, New York State Department of Financial Services, One State Street, New York, NY 10004, (212) 709-1658, email: sam.abram@dfs.ny.gov

Assessment of Public Comment

The agency received no public comment.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Workers' Compensation Insurance

I.D. No. DFS-52-11-00004-P

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

Proposed Action: Addition of Subpart 151-6 (Regulation 119) to Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301 and 302; Insurance Law, section 301; and Workers' Compensation Law, sections 15(8)(h)(4) and 151(2)(b)

Subject: Workers' Compensation Insurance.

Purpose: This regulation is necessary to standardize the basis upon which the workers' compensation assessments are calculated.

Text of proposed rule: A new sub-part 151-6 entitled Workers' Compensation Insurance Assessments is added to read as follows:

Section 151-6.0 Preamble

(a) Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the Workers Compensation Board to assess insurers, and the State Insurance Fund for the special disability fund, the fund for reopened cases, and the operations of the Board, respectively. First, the assessments are allocated to insurers, self-insurers, group self-insurers, and SIF based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, each pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

(b) Prior to January 1, 2010, each insurer paid a percentage of the allocation based on the total direct written premiums it wrote in the preceding calendar year. However, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the Board collects the portion of the allocation from each insurer. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the superintendent of insurance (the "superintendent") to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the Board and NYCIRB for collecting the assessment from insureds.

Section 151-6.1 Definitions

As used in this Part:

- (a) Board means the New York Workers Compensation Board.
- (b) Insurer means an insurer authorized to write workers' compensation insurance in this state, except for the SIF.
- (c) NYCIRB means the New York Workers Compensation Rating Board.
- (d) SIF means the State Insurance Fund.
- (e) Standard premium means
 - (i) the premium determined on the basis of the insurer's approved rates; as modified by:
 - (a) any experience modification or merit rating factor;
 - (b) any applicable territory differential premium;
 - (c) the minimum premium;
 - (d) any Construction Classification Premium Adjustment Program credits;
 - (e) any credit from return to work and/or drug and alcohol prevention programs;
 - (f) any surcharge or credit from a workplace safety program;
 - (g) any credit from independently-filed insurer specialty programs (for example, alternative dispute resolution, drug-free workplace, managed care or preferred provider organization programs);
 - (h) any charge for the waiver of subrogation;
 - (i) any charge for foreign voluntary coverage; and
 - (j) any additional charges for terrorism, and the charge for natural disasters and catastrophic industrial accidents.
 - (ii) For purposes of determining standard premium, the insurer's expense constant, including the expense constant in the minimum premium, the insurer's premium discount, and premium credits for participation in any deductible program shall be excluded from the premium base.
 - (iii) The insurer shall use the definition of standard premium set forth in this Part to report standard premium to the Board.

Section 151-6.2 Collection of assessments

Any assessments required by Workers' Compensation Law sections 15(8)(h)(4), 25-A(3) and 151(2)(b) that are collected by an insurer or SIF from policyholders shall be collected through a surcharge based on standard premium in a percentage to be determined by the superintendent in consultation with NYCIRB and the Board.

Text of proposed rule and any required statements and analyses may be obtained from: David Neustadt, Department of Financial Services, One State Street, New York, NY 10004-1511, (212) 709-1691, email: david.neustadt@dfs.ny.gov

Data, views or arguments may be submitted to: Sapna Maloor, Department of Financial Services, 25 Beaver Street, New York, NY 10004, (212) 480-4668, email: sapna.maloor@dfs.ny.gov

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

Regulatory Impact Statement

1. Statutory authority: The authority of the Superintendent of Financial Services for the promulgation of Part 151-6 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Fifth Amendment to Regulation No. 119) derives from Sections 202, 301, and 302 of the Financial Services Law ("FSL"), Section 301 of the Insurance Law, and Sections 15, 25-A, and 151 of the Workers' Compensation Law.

FSL section 301 establishes the powers of the Superintendent generally. FSL section 302 and section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to the Superintendent by the Insurance Law, the Banking Law, the Financial Services Law, or any other law of this state and to prescribe regulations interpreting the Insurance Law.

Sections 15, 25-A, and 151 of the Workers' Compensation Law, as amended by Part QQ of Chapter 56 of the Laws of 2009 require the Superintendent to define the "standard premium" upon which assessments are made for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' Compensation Board ("WCB"). Section 15 of the Workers' Compensation Law further requires workers' compensation insurers to collect the assessments from their policyholders through a surcharge based on premiums in accordance with the rules set forth by the Superintendent, in consultation with the New York Workers' Compensation Insurance Rating Board ("NYCIRB"), and the chair of the WCB.

2. Legislative objectives: (a) Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the WCB to assess insurers writing workers' compensation insurance and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the WCB, respectively. The assessments are allocated to insurers, self-insurers, group self-insurers, and the State Insurance Fund based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, the insurer pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

Prior to January 1, 2010, the Workers' Compensation Law required the WCB to assess insurers based on the total "direct premiums" they wrote in the preceding calendar year, whereas the insurers collected assessments from their insureds based on the "standard premium," which took into account high deductible policies. As high deductible policies increased in the marketplace, a discrepancy developed between the assessment an insurer collected and the assessment the insurer was required to remit to the WCB.

Therefore, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the Board collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" to ensure that insurers are not overcharged or under-charged for the assessment, and to make certain that insureds with high deductible policies are charged the appropriate assessment. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the Superintendent to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting assessments from insureds.

3. Needs and benefits: This amendment is necessary, and mandated by the Workers' Compensation Law, to standardize the basis upon which the workers' compensation assessments are calculated to eliminate any discrepancy between the amount that an insurer collects from employers and the amount that an insurer remits to the WCB.

The discrepancy in the assessment calculation and remittance became evident as a result of the proliferation of large deductible policies. In many instances, the "direct premium" paid on a large deductible policy is less than the "standard premium" would be for that policy. Insurers that offered high-deductible policies collected assessments based on the "standard premium," but the Workers' Compensation Law required the WCB to use "direct premiums" to bill insurers. Thus, in some instances, workers' compensation insurers collected from employers more money than they remitted to the WCB.

4. Costs: This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amendment itself does not impose new costs, the impact of changing the basis for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

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

6. Paperwork: This amendment requires no new paperwork. Insurers and the State Insurance Fund already collect and remit assessments to the WCB. This regulation only standardizes the basis upon which the assessments are calculated, as required by the Workers' Compensation Law.

7. Duplication: The amendment will not duplicate any existing state or federal rule.

8. Alternatives: No alternatives were considered, because Part QQ requires the Superintendent to define "standard premium" for the purpose of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting the assessment from insureds. Based on discussions with NYCIRB and the WCB, the Superintendent determined that the term "standard premium" should conform to the definition currently used by insurers, and should ensure that the definition accounts for high deductible policies.

NYCIRB has been collecting premium data on a "standard" basis since its inception nearly 100 years ago. The "standard premium" is the premium without regard to credits, deviations, or deductibles. As new credits and types of policies (such as large deductible policies) develop, NYCIRB adjusts the definition to account for the changes. The Department of Financial Services is merely adopting NYCIRB's current definition.

9. Federal standards: There are no applicable federal standards.

10. Compliance schedule: The effective date of the relevant provision of the law is January 1, 2010. The assessments must be calculated and collected as of January 1, 2010.

Regulatory Flexibility Analysis

1. Small businesses:

The Department of Financial Services finds that this rule will not impose any adverse economic impact on small businesses and will not impose any reporting, recordkeeping or other compliance requirements on small businesses.

This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as to the State Insurance Fund ("SIF"). It standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board.

The basis for this finding is that this rule is directed at workers' compensation insurers authorized to do business in New York State, none of which falls within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act. The Department of Financial Services has monitored Annual Statements and Reports on Examination of authorized workers' compensation insurers subject to this rule, and believes that none of the insurers falls within the definition of "small business," because there are none that are both independently owned and have fewer than one hundred employees. Nor does SIF come within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act, because SIF is neither independently owned nor operated, and does not employ one hundred or fewer individuals.

2. Local governments:

The amendment does not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements on any local governments. This amendment does not affect self-insured local governments, because it applies only to insurers

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as the State Insurance Fund ("SIF"). These entities do business throughout New York State, including rural areas as defined in section 102(10) of the State Administrative Procedure Act ("SAPA").

2. Reporting, recordkeeping and other compliance requirements, and professional services: This regulation is not expected to impose any reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. Insurers and SIF already collect and remit assessments to the Workers' Compensation Board ("WCB"). This amendment simply standardizes the basis upon which the assessments are calculated.

3. Costs: This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amendment itself does not impose new costs, the impact of changing the basis for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

4. Minimizing adverse impact: The amendment does not impose any impact unique to rural areas.

5. Rural area participation: This amendment is required by statute. The

entities covered by this amendment - workers' compensation insurers authorized to do business in New York State and the State Insurance Fund - do business in every county in this state, including rural areas as defined in section 102(10) of SAPA. This amendment standardizes the basis upon which the workers' compensation assessments are calculated.

Job Impact Statement

This rule will not adversely impact job or employment opportunities in New York. The rule merely standardizes the basis upon which workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board. An insurer's existing personnel should be able to perform this task. There should be no region in New York that would experience an adverse impact on jobs and employment opportunities. This rule should not have a measurable impact on self-employment opportunities.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Life Settlements

I.D. No. DFS-52-11-00005-P

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

Proposed Action: Addition of Part 381 (Regulation 198) to Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301 and 302; Insurance Law, sections 301 and sections 2137, 7803, 7804 and 7817 as added by L. 2009, ch. 499 and L. 2009, ch. 499, section 21

Subject: Life Settlements.

Purpose: To implement the provisions of chapter 499 of the Laws of 2009 as to license fees and financial accountability requirements.

Text of proposed rule: Chapter XV of Title 11 is renamed "Life Settlements".

Section 381.1 License fees and financial accountability requirements for life settlement providers.

(a) *The application for a license as a life settlement provider shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee of \$10,000.*

(b) *The financial accountability of a life settlement provider required in accordance with section 7803(c)(2)(E) of the Insurance Law, to assure the faithful performance of its obligations to owners and insureds on life settlement contracts subject to Article 78 of the Insurance Law, shall be in an amount at least equivalent to \$250,000, shall be maintained at all times and may be evidenced in one of the following manners:*

(1) *Assets in excess of liabilities in an amount at least equal to \$250,000 as reflected in the applicant's financial statements;*

(2) *A surety bond in an amount at least equal to \$250,000 placed in trust with the superintendent issued by an insurer licensed in this State to write fidelity and surety insurance under section 1113(a)(16) of the Insurance Law; or*

(3) *Securities placed in trust with the superintendent consisting of securities of the types specified in section 1402(b)(1) and (2) of the Insurance Law, estimated at an amount not exceeding their current market value, but with a total par value not less than \$250,000; provided that:*

(i) *If the life settlement provider is incorporated in another state, the securities allowed for placement in the trust may consist of direct obligations of that state; and*

(ii) *If the aggregate market value of the securities in trust falls below the required amount, the superintendent may require the life settlement provider to deposit additional securities of like character.*

(c) *The application for the biennial renewal of a life settlement provider license shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee of \$5,000.*

Section 381.2 License fees for life settlement brokers.

(a) *The application for a license as a life settlement broker shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee for each individual applicant and for each proposed sub-licensee of forty dollars for each year or fraction of a year in which a license shall be valid.*

(b) *The application for the biennial renewal of a life settlement broker license shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee for each individual applicant and for each proposed sub-licensee of forty dollars for each year or fraction of a year in which a license shall be valid.*

Section 381.3 Registration fees for life settlement intermediaries.

(a) The application for registration as a life settlement intermediary shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee of \$7,500.

(b) The application for the biennial renewal of a life settlement intermediary registration shall be made on such forms and supplements as prescribed by the superintendent and shall be accompanied by a non-refundable fee of \$2,500.

Text of proposed rule and any required statements and analyses may be obtained from: David Neustadt, New York State Department of Financial Services, One State Street, New York, NY 10004, (212) 709-1690, email: david.neustadt@dfs.ny.gov

Data, views or arguments may be submitted to: Ruth Gumaer, New York State Department of Financial Services, 25 Beaver Street, New York, NY 10004, (212) 480-4763, email: ruth.gumaer@dfs.ny.gov

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

Regulatory Impact Statement

1. Statutory authority: The Superintendent's authority for promulgation of this rule derives from sections 202, 301, and 302 of the Financial Services Law ("FSL"), section 301 of the Insurance Law, sections 2137, 7803, 7804, and 7817 of the Insurance Law as added by Chapter 499 of the Laws of 2009, and section 21 of Chapter 499 of the Laws of 2009.

Section 202 of the Financial Services Law establishes the office of the Superintendent and designates the Superintendent to be the head of the Department of Financial Services.

FSL section 301 establishes the powers of the Superintendent generally. FSL 302 and section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to him by the Insurance Law, the Banking Law, the Financial Services Law, or any other law of this state and to prescribe regulations interpreting the Insurance Law.

Section 2137 of the Insurance Law, as added by Chapter 499 of the Laws of 2009, sets forth the licensing requirements for life settlement brokers. Section 2137(h)(8) requires licensing and renewal fee be determined by the Superintendent, provided that such fees do not exceed that which is required for the licensing and renewal of an insurance producer with a life line of authority.

Section 7803 of the Insurance Law, as added by Chapter 499 of the Laws of 2009, sets forth the licensing requirements for life settlement providers. Section 7803(c)(1) requires the application for a life settlement provider's license be accompanied by a fee in an amount to be established by the Superintendent. Section 7803(h)(1) provides that an application for renewal of the license be accompanied by a fee in an amount to be established by the Superintendent. Section 7803(c)(2)(E) requires a life settlement provider to demonstrate financial accountability as evidenced by a bond or other method for financial accountability as determined by the Superintendent pursuant to regulation.

Section 7804 of the Insurance Law, as added by Chapter 499 of the Laws of 2009, sets forth the registration requirements for life settlement intermediaries. Section 7804(c)(1) requires the application for a life settlement intermediary registration be accompanied by a fee in an amount to be established by the Superintendent. Section 7804(i)(1) provides that an application for renewal of the registration be accompanied by a fee in an amount to be established by the Superintendent.

Pursuant to State Administrative Procedure Act section 202, the implementation of the fee requirements under sections 2137, 7803 and 7804 of the Insurance Law requires the promulgation of regulations.

Section 7817 of the Insurance Law, as added by Chapter 499 of the Laws of 2009, authorizes the Superintendent to promulgate regulations necessary for the implementation of provisions of Insurance Law Article 78.

Section 21(6) of Chapter 499 of the Laws of 2009 authorizes the Superintendent to promulgate rules and regulations necessary for the implementation of its provisions.

2. Legislative objectives: Sections 2137, 7803, and 7804 of the Insurance Law as added by Chapter 499 of the Laws of 2009, which became effective May 18, 2010, require the licensing of life settlement providers and life settlement brokers and the registration of life settlement intermediaries. Such sections also provide that the license and registration fees charged these persons and the financial accountability requirements that life settlement providers must demonstrate at licensing shall be established by the Superintendent.

Section 21(6) of Chapter 499 of the Laws of 2009 and section 7817 of the Insurance Law authorize the Superintendent to promulgate rules and regulations necessary for the implementation of provisions of Chapter 499 of the Laws of 2009. This rule is necessary to implement sections 2137, 7803 and 7804 of the Insurance Law.

3. Needs and benefits: Sections 2137, 7803, and 7804 of the Insurance Law requires that the Superintendent establish the application filing fees

for licensing of life settlement providers and brokers, and the registration of life settlement intermediaries, and financial accountability requirements for life settlement providers. Since such constitutes rulemaking under the State Administrative Procedure Act, these fees and accountability requirements must be established by regulation to permit the Department to accept applications for licensure by life settlement providers, life settlement intermediaries and life settlement brokers.

Therefore, adoption of this rule establishing license and registration fees and financial accountability requirements is necessary for the implementation of the life settlement legislation.

4. Costs: The rule requires an initial license application fee of \$10,000 for life settlement providers and an initial registration application fee of \$7,500 for intermediaries. Licensed providers and intermediaries are required to pay a renewal fee every two years, in the amount of \$5,000 and \$2,500, respectively. The rule also sets an annual license fee of \$40 for life settlement brokers. In addition to paying the licensing fee and renewal fees, a life settlement provider must meet financial accountability requirements by demonstrating its assets exceed its liabilities by \$250,000 at the time of initial licensing and at all times thereafter, or by placing either a surety bond or securities in an amount of not less than \$250,000 in trust with the Superintendent.

In developing the license and renewal fees for life settlement providers, life settlement intermediaries and life settlement brokers, the following were considered:

- New York Insurance Law section 332 provides that the expenses of the Department for any fiscal year, including all direct and indirect costs, shall be assessed by the Superintendent pro rata upon all domestic insurers and licensed United States branches of alien insurers domiciled in New York. Life settlement providers and life settlement intermediaries are not subject to this assessment. As a result, these expenses will be borne by insurers through the section 332 assessments, since fees collected by the Superintendent are turned over to the State's general fund, and do not directly reimburse the expenses of the Department. Nonetheless, the Superintendent believes that it is appropriate for the initial and renewal licensing and registration fees charged to life settlement providers and life settlement intermediaries to reflect, if not approximate, the costs and expenses incurred by the Department in implementing this legislation. At the same time, the Superintendent must balance other competing interests: while being reasonable and sufficient to reflect a life settlement provider's or life settlement intermediary's commitment to the New York market and a level of financial resources of such persons that will enable them to create and maintain a compliance structure necessary to ensure the faithful performance of their obligations to owners and insureds on life settlement contracts subject to Insurance Law Article 78, and yet not be too excessive so as to discourage providers and intermediaries with lesser financial resources from seeking licensing or registration. Several factors were considered in arriving at appropriate fees.
- Renewal fees for both life settlement providers and life settlement intermediaries are considerably less than the initial fees. This reflects that expenses incurred on renewal applications are generally lower than on initial application.
- Initial and renewal licensing fees charged to life settlement providers are set at rates greater than initial and renewal registration fees charged to life settlement intermediaries. The differences in such fees reflect the lesser time-based expenses associated with the registration of intermediaries than associated with provider licensing.
- New Insurance Law sections 2137 provides that the licensing or renewal fees prescribed by the Superintendent for a life settlement broker shall not exceed the licensing or renewal fee for an insurance producer with a life line of authority. In accordance with the statute, this rule sets the licensing and renewal fee for a life settlement broker at \$40, which is equal to the current licensing or renewal fee of an insurance producer with a life line of authority.

In developing the financial accountability requirements that a life settlement provider must comply with, the Superintendent considered the cash outlay of each offered compliance option. The establishment of a surety bond requires the purchase of the surety bond. The deposit of securities with the Superintendent requires the establishment of a custodian account and incurrence of the associated expenses. The maintenance of a required level of assets in excess of liabilities may require the addition of capital where such level is not currently maintained.

The rule does not impose additional costs to the Department of Financial Services or other state government agencies or local governments.

5. Local government mandates: The rule imposes no new programs, services, duties or responsibilities on any county, city, town, village, school district, fire district or other special district.

6. Paperwork: No additional paperwork should result from the provisions set by this rule.

7. Duplication: This rule will not duplicate any existing state or federal rule.

8. Alternatives: In the development of the licensing and registration fees imposed on life settlement providers and life settlement intermediaries, the Department's draft proposal was premised on the Superintendent retaining the fees to cover Department costs, and the fees were significantly higher than as included in the regulation. However, as noted, such fees are turned over to the State's general fund and thus do not directly reimburse the Department for its expenses.

The Department solicited comments from interested parties on the draft rule, which contained the higher fees. An outreach draft of the rule was posted on the Department's website for a two-week public comment period and a meeting was held at the Department on April 6, 2010 to discuss the rule with interested parties. The Life Insurance Settlement Association (LISA), a life settlement industry trade association, and other life settlement interested parties commented that the intended fees would present a financial barrier for some life settlement providers wishing to compete in the New York marketplace. LISA, as well as other interested parties, took the position that a decreased number of licensed providers in New York inhibits fair competition and industry growth, which would ultimately harm New York policyholders seeking the assistance of the secondary market for life insurance because of the lack of competition. In response to these comments, the initial license fee for life settlement providers was reduced from \$20,000 to \$10,000 and the initial registration fee for life settlement intermediaries was reduced from \$10,000 to \$7,500.

The Life Insurance Council of New York (LICONY), a life insurance trade association, has expressed support of a licensing and registration fee structure set at a level that is sufficient so that participating entities are paying for the regulation of their industry. The Superintendent attempted to balance the competing interests discussed above to arrive at a fee schedule that would be fair and equitable.

With regard to financial accountability requirements, the outreach draft posted to the Department's website for public comment had provided two options - surety bond and security deposit - to comply with such demonstration. After consideration of the comments received from LISA and other life settlement industry interested parties indicating that these options would create a financial barrier for some providers wishing to enter and operate in the New York market, the Superintendent added a third option that provides a less costly and less capital restrictive compliance alternative. The third option allows a life settlement provider to satisfy the financial accountability requirements by demonstrating that its assets exceed its liabilities by an amount no less than \$250,000. These financial accountability requirements are on a par with the requirements in many other states.

9. Federal standards: There are no minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: This regulation has been in effect on an emergency basis since April of 2010. The emergency action was necessary to establish fees and financial accountability standards in order to commence licensing life settlement providers and brokers and registration application for life settlement intermediaries, to ensure the implementation of sections 2137, 7803, and 7804 of the Insurance Law as added by Chapter 499 of the Laws of 2009. The adoption of this rule will continue the fees and financial accountability requirements currently in effect by the emergency regulation.

Regulatory Flexibility Analysis

1. Effect of the rule: This rule sets license fees for life settlement providers and life settlement brokers, registration fees for life settlement intermediaries, and financial accountability requirements for life settlement providers.

This rule is directed to life settlement providers, life settlement brokers and life settlement intermediaries. Some of these entities may come within the definition of "small business" set forth in section 102(8) of the State Administrative Procedure Act, because they are independently owned and operated, and employ 100 or fewer individuals.

This rule should not impose any adverse compliance requirements or adverse impacts on local governments. The basis for this finding is that this rule is directed at the entities allowed to conduct life settlement business, none of which are local governments.

2. Compliance requirements: The affected parties will need to accompany their applications along with fees as prescribed by this rule. Also, each life settlement provider applying for license has to comply with financial accountability requirements by demonstrating that its assets exceeds its liabilities by \$250,000 at the time of initial licensing and at all times thereafter, or by placing either a surety bond or securities in an amount of not less than \$250,000 in trust with the Superintendent.

3. Professional services: None is required to meet the requirements of this rule.

4. Compliance costs: The regulation requires a license fee of \$10,000 for life settlement providers and a registration fee of \$7,500 for life settlement intermediaries. Licensed providers and intermediaries are required to pay a renewal fee every two years, in amount of \$5,000 and \$2,500,

respectively. The rule also sets an annual license fee of \$40 for life settlement brokers. In addition to paying the licensing fee and renewal fees, a life settlement provider must comply with financial accountability requirements by demonstrating that its assets exceed its liabilities by \$250,000 at the time of initial licensing and at all times thereafter, or by placing either a surety bond or securities in an amount of not less than \$250,000 in trust with the Superintendent.

5. Economic and technological feasibility: The affected parties will need to pay licensing and registration fees as prescribed by the rule.

6. Minimizing adverse impact: The initial and renewal licensing and registration fees and financial accountability requirements for life settlement providers and life settlement intermediaries prescribed by the rule may present a financial barrier for some small-business life settlement providers and life settlement intermediaries wishing to compete in the New York market. Nonetheless, the Superintendent believes that it is appropriate for the initial and renewal licensing and registration fees charged to life settlement providers and life settlement intermediaries to reflect, if not approximate, the costs and expenses incurred by the Department in implementing this legislation. At the same time, the Superintendent must balance other competing interests: while being reasonable and sufficient to reflect a life settlement provider's or life settlement intermediary's commitment to the New York market and a level of financial resources of such persons that will enable them to create and maintain a compliance structure necessary to ensure the faithful performance of their obligations to owners and insureds on life settlement contracts subject to Insurance Law Article 78, and yet not be too excessive so as to discourage providers and intermediaries with lesser financial resources from seeking licensing or registration.

Renewal fees for both life settlement providers and life settlement intermediaries are considerably less than the initial fees. This reflects that expenses incurred on renewal applications are generally lower than on initial application.

With regard to the licensing and registration fees, alternatives (such as the direct billing of expenses, an assessment based allocation of expenses, or a reduction of licensing and registration fees charged to small-business life settlement providers and life settlement intermediaries) that may have reduced the impact of such fees on small-business life settlement providers and intermediaries were considered. However, such alternatives would require legislative authority, which could not be secured in a timeframe necessary for the timely implementation of the life settlement legislation.

With regard to the financial accountability requirements imposed on life settlement providers, after consideration of the public comment received by the Department from interested parties in response to the posting of a draft of the rule on the Department website and a meeting held with such parties to discuss the rule, the Superintendent did include in the rule an additional compliance method - demonstration of assets in excess of liabilities by an amount no less than \$250,000 - which provides a less costly and less capital restrictive alternative to the other two methods of compliance in the rule.

7. Small business and local government participation: Affected small businesses had the opportunity to comment on the draft of the rule posted on the Department website during the two-week comment period starting March 19, 2010 and to participate (in person or by conference call) in a meeting held at the Department on April 6, 2010 to discuss the rule.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: There may be some life settlement providers, life settlement brokers, and life settlement intermediaries that do business in rural areas as defined under State Administrative Procedure Act Section 102(13).

2. Reporting, recordkeeping and other compliance requirements, and professional services: This rule will not impose any reporting or record-keeping requirements on public or private entities in rural areas. The affected parties that do business in rural areas will need to comply with the license and registration fees and financial accountability requirements imposed by the rule.

3. Costs: The rule requires a license fee of \$10,000 for life settlement providers and a registration fee of \$7,500 for life settlement intermediaries. Licensed providers and intermediaries are required to pay a renewal fee every two years, in the amount of \$5,000 and \$2,500, respectively. The rule also sets an annual license fee of \$40 for life settlement brokers. In addition to paying the licensing fee and renewal fees, a life settlement provider must meet financial accountability requirements by demonstrating its assets exceed its liabilities by \$250,000 at the time of initial licensing and at all times thereafter, or by placing either a surety bond or securities in an amount of not less than \$250,000 in trust with the Superintendent.

4. Minimizing adverse impact: The initial and renewal licensing and registration fees and financial accountability requirements for life settlement providers and life settlement intermediaries prescribed by the rule may present a financial barrier for some life settlement providers and life settlement intermediaries doing business in rural areas that wish to

compete in the New York market. Nonetheless, the Superintendent believes that it is appropriate for the initial and renewal licensing and registration fees charged to life settlement providers and life settlement intermediaries to reflect, if not approximate, the costs and expenses incurred by the Department in implementing this legislation. At the same time, the Superintendent must balance other competing interests: while being reasonable and sufficient to reflect a life settlement provider's or life settlement intermediary's commitment to the New York market and a level of financial resources of such persons that will enable them to create and maintain a compliance structure necessary to ensure the faithful performance of their obligations to owners and insureds on life settlement contracts subject to Insurance Law Article 78, and yet not be too excessive so as to discourage providers and intermediaries with lesser financial resources from seeking licensing or registration.

Renewal fees for both life settlement providers and life settlement intermediaries are considerably less than the initial fees. This reflects that expenses incurred on renewal applications are generally lower than on initial application.

With regard to the fees, alternatives (such as the direct billing of expenses, an assessment based allocation of expenses, or a reduction of licensing and registration fees charged to rural area life settlement providers and life settlement intermediaries) that may have reduced the impact of such fees on life settlement providers and intermediaries doing business in rural areas were considered. However, such alternatives would require legislative authority, which could not be secured in a timeframe necessary for the timely implementation of the life settlement legislation.

With regard to the financial accountability requirements imposed on life settlement providers, after consideration of the public comments received from interested parties by the Department in response to the posting of a draft of the rule on the Department website and a meeting held with such parties to discuss the rule, the Superintendent did include in the rule an additional compliance method - demonstration of assets in excess of liabilities by an amount no less than \$250,000 - which provides a less costly and less capital restrictive alternative to the other two methods of compliance included in the rule.

5. Rural area participation: Affected parties doing business in rural areas of the State had the opportunity to comment on the draft of the rule posted on the Department website during the two-week comment period starting March 19, 2010 and to participate (in person or by teleconference) in the Department meeting on April 6, 2010 with interested parties to discuss the rule.

Job Impact Statement

The Department of Financial Services finds that this rule should have no impact on jobs and employment opportunities. This rule sets license fees for life settlement providers and life settlement brokers, registration fees for life settlement intermediaries, and financial accountability requirements that life settlement providers must demonstrate at licensing. Additional licensing and registration requirements will be established by related rulemakings in the near future.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Variable Life Insurance

I.D. No. DFS-52-11-00008-P

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

Proposed Action: Amendment of Part 54 (Regulation 77) of Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301 and 302; and Insurance Law, sections 301, 3201 and 4240

Subject: Variable life insurance.

Purpose: To amend 11 NYCRR Part 54 to authorize and provide exceptional treatment for private placement variable life insurance.

Text of proposed rule: A new subdivision (y) is added to section 54.1 to read as follows:

(y) *Private placement variable life insurance policy means any variable life insurance policy that: (i) is exempt from registration under the Federal Securities Act of 1933; (ii) includes one or more separate accounts that are exempt from registration as an investment company under the Investment Company Act of 1940; and (iii) is only available to an accredited investor, as defined in 17 CFR § 230.501(a)(2011),* or to a qualified purchaser, as defined in 15 U.S.C. § 80a-2(a)(51)(2010). ** Copies of such documents are available for public inspection at the offices of the Department of Financial Services at One Commerce Plaza, Albany, New York 12257 and 25 Beaver Street, New York, New York 10004.*

* 17 Code of Federal Regulations § 230.501(a) (revised on April 1, 2011), published by U.S. Government Printing Office, Washington, D.C. 20401.

** 15 United States Code Sec. 80a-2(a)(51) (revised on February 1, 2010), published by Office of the Law Revision Counsel, U.S. House of Representatives, Washington, D.C. 20515.

Subdivision (b) of section 54.3 is amended to read as follows:

(b) [The] *Except as set forth in subsection (g) below, the assets of such separate accounts shall be valued at least as often as variable benefits are determined, but in any event at least monthly.*

New subdivision (g) is added to section 54.3 to read as follows:

(g) *The assets of a separate account established to provide life insurance under private placement variable life insurance policies shall be valued at least as often as variable benefits are determined, but no less frequently than annually. The determination of the value of the assets of a separate account, to the extent necessary, may be based upon reasonable approximations.*

Paragraph (6) of subdivision (b) of section 54.6 is amended to read as follows:

(6) A provision designating the separate account to be used and stating that the assets of such separate account shall be valued at least as often as any policy benefits vary, but [at least] *no less frequently than annually for a private placement variable life insurance policy and monthly for any other variable life insurance policy.*

The opening clause of paragraph (7) of subdivision (b) of section 54.6 is amended to read as follows:

(7) [A] *Except in the case of a private placement variable life insurance policy, a provision that at any time during the first 18 policy months, so long as the policy is in force on a premium-paying basis, the owner may exchange the policy without evidence of insurability for a policy of general account life insurance on the life of the insured for the same amount of insurance as the initial face amount of the variable life insurance policy, and on a plan of insurance specified in the policy, subject to the following requirements:*

New paragraphs (15) and (16) of subdivision (b) are added to section 54.6 to read as follows:

(15) *For a private placement variable life insurance policy, a provision stating that the payment of variable death benefits shall be made no later than 30 days from the date the request for payment and all necessary documentation are received.*

(16) *For a private placement variable life insurance policy, a provision stating that the payment of cash surrender values, policy loans, partial withdrawals or partial surrenders shall be made as expeditiously as possible but in no event later than 15 months from the date the request for payment is received.*

The opening paragraph of section 54.7 is amended to read as follows:

The policy value and cash surrender value [of each variable life insurance policy] shall be determined *no less frequently than annually for a private placement variable life insurance policy and at least monthly for any other variable life insurance policy.* A summary of the method of computation of cash surrender values and other nonforfeiture benefits shall be described in the policy; a complete statement of the method of computation shall be filed with the superintendent. Such method shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that it complies with subdivision (a) or (b) of this section:

Section 54.7(b)(2)(i)(c) is amended to read as follows:

(c) A deferred acquisition and other charge may be charged against the policy value in any policy year 2 through [15]20, such that the total of all such charges imposed to date plus the surrender charge for that year does not exceed the maximum initial surrender charge. The deferred acquisition and other charge in any one year may not exceed the maximum allowable surrender charge for that year. Similar deferred acquisition and other charges may be imposed with respect to an increase in face amount.

Paragraph (3) of subdivision (b) of section 54.7 is amended to read as follows:

(3) Any surrender charge in paragraph (2) of this subdivision must be such that [at the end of] *during* any policy year it does not exceed the maximum initial surrender charge that would be allowed multiplied by the ratio of [ax + t; 15-t] to ax; 15] *a life annuity due for age x+t for 20-t years to a life annuity due for age x for 20 years* based on the mortality table and interest rate used in calculating the net level whole life annual premiums. Furthermore, any such surrender charge may not exceed the maximum initial surrender charge less the sum of all deferred acquisition and other charges made to date against the policy value. For these annuity values, x is the age at [which] *the effective date of the surrender charge [is created]* and t is the [duration] *number of years completed since [of] the effective date of the surrender charge.*

Section 54.7(b)(5)(iii) is amended to read as follows:

(iii) [At least once each year, the] *The [insured] policyholder [has]*

shall have the option to transfer all separate account funds to the general account and apply [his] the policy's cash surrender value to purchase a guaranteed fixed paid-up benefit at least once every five years for a private placement variable life insurance policy and at least once each year for any other variable life insurance policy.

The opening paragraph of section 54.9 is amended to read as follows:

An insurer delivering or issuing for delivery in this State any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, a private placement offering memorandum in the case of a private placement variable life insurance policy or a prospectus included in a registration statement relating to the [policies which satisfies] policy in the case of any other variable life insurance policy. The prospectus must satisfy the requirements of the federal securities [Act of 1933 and which was] laws, have been declared effective by the Securities and Exchange Commission, and [which] include[s] the following information:

Subdivision (d) of section 54.10 is re-lettered subdivision (e) and a new subdivision (d) is added to read as follows:

(d) A prominent statement, in the case of a private placement variable life policy, that due to the illiquid nature of the investment options, the payment of the death benefit, the cash surrender value, policy loans, partial withdrawals or partial surrenders, as applicable, may be delayed. The statement shall advise the applicant to refer to the policy for further details on any delay of payments.

(e) A notice that the following are available upon request: Illustrations of benefits, including death benefits, policy values and cash surrender values. Such illustrations shall be in a form and content acceptable to the superintendent.

Text of proposed rule and any required statements and analyses may be obtained from: David Neustadt, New York State Department of Financial Services, One State Street, New York, NY 10004, (212) 709-1690, email: david.neustadt@dfs.ny.gov

Data, views or arguments may be submitted to: Deborah Kahn, New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, (518) 474-7668, email: deborah.kahn@dfs.ny.gov

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

Regulatory Impact Statement

1. Statutory authority: The Superintendent's authority for the promulgation of Insurance Regulation 77 (11 NYCRR 54) derives from sections 202, 301 and 302 of the Financial Services Law ("FSL") and sections 301, 3201 and 4240 of the Insurance Law.

Section 202 of the Financial Services Law establishes the office of the Superintendent and designates the Superintendent to be the head of the Department of Financial Services.

Section 301 of the Financial Services Law establishes the powers of the Superintendent generally.

Section 302 of the Financial Services Law and Section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to him by the Insurance Law, the Banking Law, the Financial Services Law, or any other law of this state and to prescribe regulations interpreting the Insurance Law.

Section 3201 of the Insurance Law prohibits a policy form from being delivered or issued for delivery in this state unless it has been filed with and approved by the Superintendent as conforming to the requirements of the Insurance Law and not inconsistent with law.

Section 4240 authorizes the Superintendent to promulgate regulations relating to separate accounts.

2. Legislative objectives: In 1962, the Legislature added Insurance Law § 4240 to authorize domestic life insurers to establish separate accounts and write separate account agreements. The section provides the basis for the issuance of variable life insurance policies and variable annuities, wherein the policyholder may allocate portions of the account value of the policy or premiums paid into the policy to investment options within the separate account that are selected by the policyholder. Pursuant to Insurance Law § 4240, the income, gains and losses from the assets allocated to a separate account are required to be credited to, or charged against, the separate account and segregated from the assets, income, gains or losses of the company's general account and other separate accounts. Accordingly, the policyholder bears the risk of the gains and losses of the investments selected under the policy. Insurance Law § 4240(d)(7) authorizes the Superintendent to regulate the issuance and sale of separate account agreements, provides that the Superintendent may promulgate regulations relating to the separate accounts that may be appropriate to carry out the provisions of Insurance Law § 4240 and, insofar as applicable to Insurance Law § 4240, other provisions of the Insurance Law.

In accordance with the statute, the Superintendent promulgated New York Comp. Codes R. & Reg., tit. 11, Part 54 ("Insurance Regulation

77") which, in relevant part, requires that the assets of a separate account be valued monthly. The regulation also sets forth requirements in relation to death benefits, cash surrender values, policy loans, partial withdrawals and partial surrenders. Generally, the assets of a separate account are publicly traded on a stock exchange and can be valued or liquid on any day that the stock market is open.

3. Needs and benefits: The life insurance industry believes that in order to remain competitive with other financial institutions, it must offer variable life insurance policies containing private placement separate accounts, known as private placement life insurance policies, to consumers who meet the definition of "accredited investor" as set forth in 17 CFR § 230.501(a)(2011) or "qualified purchaser" as set forth in 15 USC § 80a-2(a)(51)(2010). Private placement investments are investments that: (1) are not publicly traded; (2) may only be sold to persons that meet the specified income or net worth criteria of an "accredited investor" or "qualified purchaser", as set forth in federal securities law, and; (3) are exempt from registration with the SEC under Section 4(2) of the Securities Act of 1933 and Rules 504, 505 or 506 of Regulation D there under, and Section 3(c) of the Investment Company Act of 1940. Insurance Regulation 77 as promulgated in 1985 did not provide for the use of private placement investments in variable life insurance policies. The investment options addressed under Insurance Regulation 77 are publicly traded on a stock exchange and allow for ready valuation and liquidity of the assets of a variable life insurance policy. Since private placement investments by their nature are not as liquid as investments traded on a stock exchange, private placement variable life insurance policies require longer time frames for valuation and liquidity purposes. This amendment to Insurance Regulation 77 would add the provisions necessary to accommodate the mechanics of private placement investments in a variable life insurance policy, and would allow consumers who meet the federal definition of "accredited investor" or "qualified purchaser" as incorporated by reference in the regulation, to purchase private placement variable life insurance policies. In accordance with this amendment, these policies would: (1) provide for valuation of the assets at least annually, (2) provide for the payment of variable death benefits no later than 30 days from the date an insurer receives a request for payment and the necessary documentation and (3) provide for the payment of cash surrender values, policy loans, partial withdrawals or partial surrenders no later than 15 months from the date an insurer receives a the request for payment. Although consumers will receive a detailed private placement offering memorandum prior to purchase, this amendment to Insurance Regulation 77 requires insurer to inform consumers that due to the illiquid nature of the investment options, the payment of the death benefit, the cash surrender value, policy loans, partial withdrawals or partial surrenders, as applicable, may be delayed. The statement must also advise the applicant to refer to the policy for further details on any delay of payments.

4. Costs: There will be no costs to life insurers that do not choose to offer private placement variable life insurance. Life insurers that wish to offer these policies will be required to submit policy forms, but that cost will not exceed normal form filing expenses for similar products in New York. Costs to the Department of Financial Services will be minimal. All life insurance and annuity policy forms are required to be submitted to the Department for approval. The cost to the Department will be minimal as existing personnel are available to process the additional private placement variable life insurance policy forms submitted as a result of the proposed amendment. The Department does not expect to receive a significant volume of these filings. There are no costs to other state government agencies or local governments.

5. Local government mandates: The proposed amendment imposes no new programs, services, duties or responsibilities on any county, city, town, village, school district, fire district or other special district.

6. Paperwork: Life insurers that wish to offer private placement variable life insurance policies will be required to submit new policy forms, but the paperwork will not exceed normal form filing paperwork for similar products in New York.

7. Duplication: The proposed amendment does not duplicate any existing state or federal law or regulation. The amendment is consistent with certain federal securities law requirements that restrict the purchase of private placement investments to certain classes of investors.

8. Alternatives: As part of the drafting process, the Department consulted with the Life Insurance Council of New York ("LICONY"). LICONY is a trade group representing a significant number of life insurers authorized to do business in New York. LICONY offered a number of comments, some of which have been included in the proposed amendment. LICONY initially sought an amendment that would provide for unlimited liquidity and valuation delays. The proposal limits liquidity delays and valuation periods as described above. The Department believes that to allow longer or indefinite liquidity or valuation delays would be excessive and would provide the potential for abuse.

The Department also conducted outreach by contacting several con-

sumer groups, including the Consumer Federation of America and the Center for Economic Justice, for their input regarding these amendments. The Department also contacted the Independent Insurance Agents of New York for input. No comments were received from any of these parties.

9. Federal standards: There are federal requirements for private placement investments. This amendment authorizes the sale of private placement variable life insurance policies only to consumers who meet the definition of "accredited investor" as defined in 17 CFR § 230.501(a)(2011) or "qualified purchaser" as defined in 15 U.S.C. § 80a-2(a)(51)(2010).

10. Compliance schedule: The amendment will be effective upon publication in the State Register. Life insurers that choose to offer a private placement variable life insurance policy will be required to file the appropriate policy forms for review and approval by the Department. When a life insurer's policy form is approved, it will be able to market and sell the approved policy.

Regulatory Flexibility Analysis

1. Small businesses: The Department of Financial Services finds that this amendment will not impose any adverse economic impact or any reporting, recordkeeping or other compliance requirements on small businesses. The basis for this finding is that this rule is directed at life insurers authorized to do business in New York State, none of which fall within the definition of "small business" as found in section 102(8) of the State Administrative Procedure Act. The Department of Financial Services has reviewed filed Reports on Examination and Annual Statements of these authorized life insurers and believes that none of them fall within the definition of "small business" because there are none which are both independently owned and have less than one hundred employees.

2. Local governments: The amendment does not impose any adverse economic impact on local governments, including reporting, recordkeeping, or other compliance requirements.

Rural Area Flexibility Analysis

The Department of Financial Services finds that this amendment will not impose any adverse impact, any reporting, recordkeeping or other compliance requirements or any need for professional services on any public or private entities in rural areas. This amendment provides for an exception from regulatory standards otherwise applicable to variable life insurance marketed to the general public. The exception is only for variable life insurance policies intended for the private placement market. The amendment does not impose any reporting, recordkeeping, other compliance requirements or any need for professional services on insurers or other entities, including those that are located in rural areas.

Job Impact Statement

This rule will not adversely impact job or employment opportunities in New York. The rule amends the regulatory standards applicable to variable life insurance marketed to the general public with respect to those policies intended only for the private placement market.

The rule is likely to have no measurable impact on jobs and employment opportunities because life insurers' existing personnel should be able to amend policy forms to conform to the requirements of this Part. In addition, no region in New York should experience an adverse impact on jobs and employment opportunities. Finally, this rule would not have a measurable impact on self-employment opportunities.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Special Risk Insurance

I.D. No. DFS-52-11-00018-P

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

Proposed Action: Amendment of Part 16 (Regulation 86) of Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202, 301 and 302; and Insurance Law, sections 301, 307 and 308 and art. 63

Subject: Special Risk Insurance.

Purpose: To revise the regulation to comply with Chapter 490 of the Laws of 2011.

Text of proposed rule: Section 16.0 is amended to read as follows:

Section 16.0 Introduction.

This Part implements article 63 of the Insurance Law and establishes methods, procedures and reports for licensing, facilitating, monitoring and verifying compliance with the requirements of the Insurance Law. In effect, article 63 allows special risks that are jumbo in dimensions or exotic in nature to be written, free of filing rates or policy forms with the superintendent, in what is sometimes called the "Free Trade Zone". In addition,

article 63 allows certain coverage for "large commercial insureds" to be written as special risks. Although filing is not required except as specified in section 6303, rates and policy forms applied to special risks must still satisfy governing standards set forth in the Insurance Law and regulations.

Section 16.1 is amended to read as follows:

Section 16.1 Definitions.

For purposes of this Part:

(a) Accident and health insurer has the meaning set forth in section 107(a)(1) of the Insurance Law.

(b) Authorized insurer has the meaning set forth in section 107(a)(10) of the Insurance Law.

(c) Large commercial insured has the meaning set forth in section 6303(b)(1) of the Insurance Law.

(d) Life insurer has the meaning set forth in section 107(a)(28) of the Insurance Law.

(e) Major type of insurance as used in this Part means the annual statement line of business based on the coverage part with the highest estimated premium at the time of issuance of the certificate of insurance.

(f) Medical malpractice insurance has the meaning set forth in section 5501(b) of the Insurance Law.

[(d)] (g) Net premiums written means gross premiums (direct and assumed premiums, including policy and membership fees, less return premiums and premiums for policies not taken) less reinsurance ceded.

[(e)] (h) Property/casualty insurer means an insurer licensed pursuant to article 41 or 61 of the Insurance Law.

[(f)] (i) Special risk manager has the meaning set forth in section 6303(b)(2) of the Insurance Law.

(j) Special risk means:

(1) Class 1. Where all or part of the insured's business operations, for which coverage is authorized by the kinds of insurance defined in section 1113(a) of the Insurance Law, is insured in a single policy written in accordance with section 6303 of the Insurance Law, and which is written with or is reasonably expected to produce a billed annual premium of at least:

(i) \$100,000 for at least one kind of insurance; or

(ii) \$200,000 for more than one kind where the premium for any one kind of insurance does not exceed \$100,000.

(2) Class 2. Coverages that are:

(i) of an unusual nature, a high loss hazard or difficult to place; and

(ii) enumerated in the list contained in section 16.12(e) of this Part, or additions thereto made pursuant to section 16.8(f) of this Part.

(3) Class 3. Coverage other than medical malpractice issued to a large commercial insured that employs or retains a special risk manager to assist in the negotiation and purchase of a policy exempted under this article, provided, however, that:

(i) the special risk manager is not employed by the insurer issuing the policy or any person in the insurer's holding company system; and

(ii) the special risk manager is licensed as an insurance producer in this state pursuant to Insurance Law article twenty-one, unless exempted from licensing therein.

Section 16.3 is amended to read as follows:

Section 16.3. Disclosure to insureds.

(a) The following notice shall appear conspicuously on the front page of each binder, policy, contract, rider or endorsement, and on all subsequent additions thereto, issued or renewed under Class 1 or 2 pursuant to section 6303(a)(1) or (2) of the Insurance Law:

NOTICE: THESE POLICY FORMS AND THE APPLICABLE RATES ARE EXEMPT FROM THE FILING REQUIREMENTS OF THE NEW YORK STATE INSURANCE [DEPARTMENT] LAW AND REGULATIONS. HOWEVER, [SUCH] THE FORMS AND RATES MUST MEET THE MINIMUM STANDARDS OF THE NEW YORK INSURANCE LAW AND REGULATIONS.

(b) The following notice shall appear conspicuously on the front page of each binder, policy, contract, rider or endorsement, and on all subsequent additions thereto, issued or renewed under Class 3 pursuant to section 6303(a)(3) of the Insurance Law:

NOTICE: THESE POLICY FORMS ARE NOT SUBJECT TO THE APPROVAL REQUIREMENTS AND THE APPLICABLE RATES ARE EXEMPT FROM THE FILING REQUIREMENTS OF THE NEW YORK STATE INSURANCE LAW AND REGULATIONS. HOWEVER, THE FORMS AND RATES MUST MEET THE MINIMUM STANDARDS OF THE NEW YORK INSURANCE LAW AND REGULATIONS.

(c) [The] Each "Notice" required by subdivision (a) or (b) of this section shall be in bold capital letters, no less than three-eighths of an inch in height, enclosed in a border.

Section 16.4 is amended to read as follows:

Section 16.4 Policy forms, certificate of insurance and other standards.

(a) Every binder, policy, contract, rider and endorsement issued pursuant to section 6301 of the Insurance Law on special risks located or resi-

dent in New York State shall comply with minimum standard policy provisions of the Insurance Law and this Title.

(b) For a coverage coded as a class 3 risk pursuant to Section 16.12 of this Part, the insurer shall electronically file with the superintendent, in a form and manner acceptable to the superintendent:

(1) Within one business day of binding the insurance coverage, a certificate of insurance evidencing the existence and terms of the policy;

(2) Within 30 days from the inception date of the policy:

(i) the certificate of insurance specified in Section 16.4(b)(1) of this part; and

(ii) the following information:

(a) The identity of the insured and a statement that the insured meets the minimum commercial risk premium and financial condition standards for a "large commercial insured" pursuant to Section 6303(b) of the Insurance Law;

(b) Major type of insurance;

(c) Rate services organization classification (such as Insurance Service Organization classification), if applicable, or, if not applicable, a description of the class to be written;

(d) Risk manager name, employer and contact information, including mailing address, phone number and email address, and a statement that the insurer has verified that the risk manager who assisted in the negotiation and purchase of the policy on behalf of the insured meets the qualifications required by section 6303(b)(2) of the Insurance Law; and

(e) The New York producer license number, if the risk manager is required to be a New York licensed producer; and

(3) with respect to a policy form that has not been previously filed with the superintendent, the policy form, within three business days after first delivery of a policy using the form, but no later than 60 calendar days after the inception date of the policy.

(c)(1) An insurer required to make a filing or a submission to the superintendent electronically pursuant to this Part may apply to the superintendent for an exemption from the electronic filing requirement by submitting a written request to the superintendent for approval at least 30 days in advance of making the filing or submission.

(2) The request for an exemption shall:

(i) Identify the time period for which the insurer is requesting the exemption, and

(ii) Specify whether the insurer is making the request for an exemption based upon undue hardship, impracticability, or good cause, and set forth a detailed explanation as to the reason that the superintendent should approve the request.

Section 16.6(a) is amended to read as follows:

(a) An authorized insurer may apply for a special risk license to transact business written pursuant to section 6302 of the Insurance Law by completing an application form, prescribed by the superintendent and available from the Property [Companies] Bureau of the [Insurance] Department of Financial Services.

Section 16.8 is amended to read as follows:

Section 16.8 Operational requirements.

(a) Class 1[or], class 2 or class 3 coverages may be provided only to:

(1) a single entity; or

(2) two or more related entities, in each of which the same person, group of persons, or corporation holds a controlling interest.

(b) Class 1, [or] class 2 or class 3 coverages may not be provided in a manner that would constitute a group policy within the meaning of Part 153 of this Title.

(c) [Covered policies as defined in section 3425(a)(1) and (2) of the Insurance Law shall not be written as class 1 or class 2 risks.

(d) The kinds of business defined in the following numbered paragraphs of section 1113(a) of the Insurance Law shall not be written as class 1 risks:

(1) life insurance;

(2) annuities;

(3) accident and health insurance;

(15) workers' compensation and employers' liability;

(18) title insurance;

(23) mortgage guaranty insurance;

(24) credit unemployment insurance; or

(25) financial guaranty insurance.] (1) Except as provided in subparagraph (2) of this subdivision, a policy may be written pursuant to Insurance Law article 63 and this Part if the policy provides only one or more of the kinds of insurance specified in Insurance Law section 1113(a)(4) through (14), (16), (17), (19) through (22), (27) and (29).

(2) A covered policy, as defined in section 3425(a)(2) of the Insurance Law or a policy providing coverage pursuant to Insurance Law section 1113(a)(1), (2), or (3) may be written as a class 2 risk if the coverage is included in the list of eligible class 2 risks contained in section 16.12(e) of this Part.

(3) A medical malpractice insurance policy may not be written as a class 3 risk.

(d) Notwithstanding any other provision of this Part, a policy may not be written pursuant to Insurance Law article 63 and this Part with respect to:

(1) Insurance specified in Insurance Law section 2328;

(2) Insurance specified in Insurance Law section 2305(b) except medical malpractice insurance may be written as a class 1 or 2 risk; or

(3) Insurance required to satisfy any financial responsibility requirement of this State.

(e) Where a policy includes coverage for both New York and non-New York exposures, the total premium for all exposures may be used for purposes of determining class 1 or class 3 eligibility pursuant to section 16.1(j) of this Part. However, a report filed with the superintendent showing special risk premiums and losses shall only include risks related to New York exposures unless the statement filing instructions specify otherwise.

(f)(1) Application may be made to the superintendent for adding a class to the list of eligible class 2 risks enumerated in section 16.12(e) of this Part.

(2) In reviewing such an application, the superintendent shall consider the following factors:

(i) whether the insurance coverage provided protects from perils or risks that are neither contained in, nor conducive to the use of, generic policy forms or filed rate schedules;

(ii) whether the type of insurance risk contains a substantial degree of peril or hazard that makes use of generic policy forms or filed rate schedules impractical; and

(iii) the extent to which the type of coverage is unavailable from authorized insurance markets.

(3) Class 2 additions shall be published in the State Register.

(4) Applications to the superintendent to add classes to the class 2 risk list shall include:

(i) a detailed description of the class for which filing exemptions are requested;

(ii) a statement indicating the reasons why the class should be considered unusual, having a high loss hazard, or difficult to place; and

(iii) a statement explaining why the filing requirements of the Insurance Law with regard to rates and forms would impose an undue impediment to the effective writing of the particular class of business in this State.

(g) Coverages qualifying as class 2 risks may be provided by separate individual policies or incorporated by endorsement into other policies. When coverages for class 2 risks are provided by endorsement, only the policy forms and rates applicable to such endorsement qualify for filing exemptions pursuant to this Part.

(h) No policy may be issued or renewed pursuant to class 3 on or after the date specified in Insurance Law section 6303(a)(3).

Section 16.12 (a) is amended to read as follows:

Section 16.12. Coding of class 1, [and] class 2, and class 3 risks.

(a) The principal operations of class 1 and class 3 risks shall be coded in accordance with the classification codes filed by the Insurance Services Office under the commercial statistical plan.

Subdivision (d) of Section 16.12 is amended to read as follows:

(d)(1) Special risks classified under class 2 [which generates] that generate a premium in [the] an amount that qualifies as a class 1 risk shall, for reporting purposes, be designated as class 2 risks; and

(2) Special risks classified under class 2 that also qualify as class 3 risks shall, for reporting purposes, be designated as class 2 risks.

Section 16.13 is repealed.

Text of proposed rule and any required statements and analyses may be obtained from: David Neustadt, NYS Department of Financial Services, One State Street, New York, NY 10004, (212) 709-1690, email: david.neustadt@dfs.ny.org

Data, views or arguments may be submitted to: Hoda Nairooz, NYS Department of Financial Services, 25 Beaver Street, New York, NY 10004, (212) 480-5587, email: hoda.nairooz@dfs.ny.gov

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

Regulatory Impact Statement

1. Statutory authority: Financial Services Law (FSL) Sections 202, 301 and 302, Insurance Law (NYIL) Sections 301, 307 and 308, and NYIL Article 63.

These sections establish the superintendent's authority to promulgate regulations establishing standards for governing Special Risk Insurance by exempting insurers from certain rate and policy form approval requirements.

FSL section 202 establishes the office of the Superintendent. FSL section 301 establishes the powers of the Superintendent generally. FSL 302 and Section 301 of the Insurance Law, in material part, authorize the Superintendent to effectuate any power accorded to him by the Insurance Law, and to prescribe regulations interpreting the Insurance Law.

NYIL Section 307 requires every authorized insurer and fraternal benefit society in New York to file an annual statement (audited financial statement) showing its condition at the last year end. The section further establishes specific requirement for the statements and penalties for failure to file timely.

Section 308 permits the Superintendent to request information from insurers in relation to transactions or conditions or any matter connected herewith.

Article 63 has long permitted special risks that are jumbo in dimensions or exotic in nature to be written, free of filing rates or policy forms, in what is sometimes called the "Free Trade Zone". As amended, Section 6303(a) now permits policies to be written with respect to "large commercial insureds," as such term is defined in that section. Section 6304 requires the Superintendent to promulgate rules and regulations implementing the provisions of this article by establishing methods, procedures and reports for licensing and for facilitating, monitoring and verifying compliance with this article.

2. Legislative objectives: Article 63 of the Insurance Law establishes standards for governing Special Risk Insurance. Section 6303 exempts insurers from certain rate and policy form approval requirements. Chapter 490 of the Laws of 2011 amended Article 63 of the Insurance Law to add a new exempted category of risks (Class 3 risks). The Class 3 risks are "large commercial insureds" that meet the qualifications specified in Article 63, including that a large commercial insured employ or retain a special risk manager to assist in the negotiation and purchase of the policy. Section 6304 requires the superintendent to promulgate rules and regulations implementing the provisions of Article 63 by establishing methods, procedures and reports for licensing and for facilitating, monitoring and verifying compliance with Article 63.

3. Needs and benefits: Chapter 490 of the Laws of 2011 amended Article 63 of the Insurance Law by introducing Class 3 risks to be written in New York by insurers licensed to write special risk insurance for "large commercial insureds," as defined in the amendment, provided that the insurers make certain informational filings with the Superintendent. The addition of the Class 3 risks was intended to enhance the ability of insurers to underwrite large and unusual risks in the New York market, increase speed to market for certain insurance products not currently exempted and facilitate more streamlined economic development in New York, as existing and emerging businesses that need to insure large or unusual risks would have quick access to the insurance they need. The rule sets forth the requirements for writing Class 3 risks and the procedures for insurers to make the required filings as stated in Chapter 490.

4. Costs: This rule imposes no compliance costs on state or local governments. While there may be some additional costs incurred by the Department resulting from the new filings, this should be minimized by having the filings made electronically. This rule does not impose additional costs upon insurers since the additional special risk exemption is optional, not mandatory, on the part of the insurer. If an insurer chooses to issue a Class 3 policy, then the submission of a certificate of insurance and a policy form (if not previously filed) is required by the statute, and the rule is only implementing the statutory requirement. Although the filing of the certification is not mandated by the statute, it is necessary for the proper monitoring by the Department of new Class 3 business. However, since the Department has an electronic means for insurers to use for the submission of these filings, these additional costs will be nominal.

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

6. Paperwork: With respect to the new Class 3 filings, the rule requires an insurer to submit the certificate of insurance for each risk and to complete a certification form in a manner acceptable to the Superintendent. The Department intends to develop a standard certification form for insurers to use and plans to post the form on the Department's web site along with instructions for completing the form. Insurers are also required to file any policy form that has not been previously filed with the Superintendent, for informational purposes. Submissions of the certificate of insurance and of any policy form not previously filed with the Superintendent are statutory requirements of the new law. The completion and submission of the form to accompany the certificate of insurance is to facilitate compliance with the requirements with respect to Class 3 risks.

7. Duplication: This rule will not duplicate any existing state or federal rule.

8. Alternatives: The rule requires the submission of a certificate of insurance along with a form that includes additional information such as the identity of the insured and the risk manager utilized by the "large commercial insured" (the above-referenced certification form). The Department performed outreach with various insurer trade associations; the associations stated that it would be difficult for them to comply with the requirement to file electronically the certificate of insurance and the certification form within one business day from binding the policy. After fur-

ther consideration of these comments, the Department revised the regulation to allow insurers to submit the certificate of insurance through a dedicated e-mail box within one day from binding the policy in order to comply with the statute. In addition, in order to provide more time for insurers to file the certification form the rule has been revised to require insurers to electronically file the certificate of insurance again along with the certification form within 30 days from the inception date of the policy. The alternative of not requiring the certification form to be submitted with the certificate of insurance was considered and rejected because the form will expedite the review of the filings, enhance compliance with the statute and rule and enable the Department to more easily monitor the types of Class 3 risks that insurers are writing.

The Department also received comments asking that the new notice required by the regulation to be placed on policies should be combined with the existing notice. However, upon consideration, the Department felt that combining the two notices would be confusing because of the differing requirements between Class 1 and 2 with new Class 3.

The rule requires Class 3 risk filings to be submitted electronically, unless the insurer is granted a hardship exemption, in which case a paper filing will be accepted. The alternative of accepting paper submissions from all insurers was considered and rejected as electronic submission of Class 3 risk filings will facilitate the monitoring and the generation of reports for Class 3 risks.

9. Federal standards: There are no minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: The effective date of the enabling legislation, Chapter 490 of the Laws of 2011, is November 15, 2011. Pursuant to the law, insurers may start writing the Class 3 risks as of the effective date and are required to file the certificate of insurance with the Department within one business day of binding the insurance coverage. Insurers are also required to file a policy form, which has not been previously filed with the Superintendent, for informational purposes, but both of these filings are required by the statute.

Regulatory Flexibility Analysis

1. Small businesses:

The Department of Financial Services finds that this rule will not impose any adverse economic impact on small businesses and will not impose any reporting, recordkeeping or other compliance requirements on small businesses. The basis for this finding is that this rule is directed at property/casualty insurance companies licensed to do business in New York State, none of which falls within the definition of "small business" as found in section 102(8) of the State Administrative Procedure Act. The Department of Financial Services has monitored Annual Statements and Reports on Examination of authorized property/casualty insurers subject to this rule, and believes that none of the insurers falls within the definition of "small business", because there are none that are both independently owned and have fewer than one hundred employees.

2. Local governments:

The rule does not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements on any local governments. The basis for this finding is that this rule is directed at property/casualty insurance companies, none of which are local governments.

Rural Area Flexibility Analysis

The Department of Financial Services finds that this rule does not impose any additional burden on persons located in rural areas, and it will not have an adverse impact on rural areas. This rule applies uniformly to regulated parties that do business in both rural and non-rural areas of New York State.

Job Impact Statement

The Department of Financial Services finds that this rule should have no adverse impact on jobs or economic opportunities in New York State. It merely revises the filing requirements and governing standards of special risk insurance to add a new exempted category of risks (Class 3 risks) for certain "large commercial insureds" in order to comply with Chapter 490 of the Laws of 2011. The number of insurance company personnel necessary to submit Class 3 filings should be no different than submitting these risks under the prior law.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Independent Adjusters

I.D. No. DFS-52-11-00019-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 rule making to amend Part 26 (Regulation 25) of Title 11 NYCRR.

Statutory authority: Financial Services Law, sections 202 and 302; and Insurance Law, sections 301, 307 and 308 and art. 63

Subject: Independent Adjusters.

Purpose: To authorize the licensing of independent adjusters for multi-peril crop insurance.

Text of proposed rule: Section 26.3 is hereby amended to add a new subdivision (k) to read as follows:

(k) *Independent adjuster, multi-peril crop insurance. The independent adjuster, multi-peril crop insurance, shall have authority to investigate and adjust all claims arising under policies of multi-peril crop insurance that are reinsured by the Risk Management Agency, an agency of the United States Department of Agriculture.*

Section 26.4 is hereby amended to add a new subdivision (c) to read as follows:

(c) *In order to qualify for a multi-peril crop adjuster's license, an applicant must have received accreditation from the federal Crop Adjuster Proficiency Program, administered by the National Crop Insurance Services, Inc.*

A new Section 26.7 is promulgated to read as follows:

§ 26.7 *Reporting of actions*

An adjuster shall report to the superintendent any administrative action taken against the adjuster in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter, including decertification or other action related to the adjuster's proficiency to adjust multi-peril crop insurance claims. The report shall include a copy of the order, consent to order and any other relevant legal documents.

Text of proposed rule and any required statements and analyses may be obtained from: David Neustadt, NYS Department of Financial Services, One State Street, New York, NY 10004, (212) 709-1690, email: david.neustadt@dfs.ny.org

Data, views or arguments may be submitted to: Sam Wachtel, NYS Department of Financial Services, 25 Beaver Street, New York, NY 10004, (212) 480-5269, email: samuel.wachtel@dfs.ny.gov

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

Consensus Rule Making Determination

The Seventh Amendment to Regulation 25 will authorize the licensing of independent adjusters for multi-peril crop insurance. In order to qualify for a multi-peril crop adjuster's license, an applicant must have received accreditation from the federal Crop Adjuster Proficiency Program, administered by the National Crop Insurance Services, Inc ("NCIS"). Multi-peril crop adjuster's shall have authority to investigate and adjust all claims arising under policies of multi-peril crop insurance that are reinsured by the Risk Management Agency ("RMA"), an agency of the United States Department of Agriculture.

The RMA, through the FCIC, provides crop insurance to American producers. Seventeen private-sector insurance companies sell and service the policies. RMA develops and/or approves the premium rate, administers premium and expense subsidies, approves and supports products, and reinsures the companies.

The 2012 Standard Reinsurance Agreement (<http://www.rma.usda.gov/pubs/ra/sraarchives/2sra.pdf>) provides that all loss adjusters adjusting eligible crop insurance contracts must be certified by the FCIC before they can conduct any loss adjustment. Loss adjusters may obtain certification by completing the training requirements specified in the reinsurance agreement. Further provisions of the 2012 Standard Reinsurance Agreement provide that no state or local regulatory authority, including without limitation a State's insurance commissioner, department, or comparable public authority, may enforce or seek to enforce any provision of the Act, the regulations, this Agreement, or any FCIC procedures, without the prior written consent of FCIC.

This rule is determined by the agency to be a consensus rule, as defined in State Administrative Procedure Act, § 102(11) (SAPA), and is proposed pursuant to subparagraph (i) of paragraph (b) of subdivision one of section two hundred two of SAPA. Accordingly, it is exempt from the requirement to file a Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Businesses and Local Governments or a Rural Area Flexibility Analysis.

Job Impact Statement

This amendment is not likely to impact job or employment opportunities in New York. This amendment authorizes the licensing of independent adjusters for multi-peril crop insurance and establishes the procedures to allow adjusters to obtain such authorization. It creates an additional business opportunity for independent adjusters.

The independent adjusters that apply for authorization to write multi-

peril crop insurance will, in almost all cases, already have independent adjuster licenses for other lines of insurance. In any event, the amendment will either have no effect or a positive affect on job opportunities in New York State.

Department of Motor Vehicles

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Franklin County Motor Vehicle Use Tax

I.D. No. MTV-52-11-00006-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 rule making to amend section 29.12(ai) of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a) and 401(6)(d)(ii); and Tax Law, section 1202(c)

Subject: Franklin County motor vehicle use tax.

Purpose: To impose a Franklin County motor vehicle use tax.

Text of proposed rule: Section 29.12 is amended by adding a new subdivision (ai) to read as follows:

(ai) *Franklin County. The Franklin County Legislature adopted a resolution on September 15, 2001, to establish a Franklin County Motor Vehicle Use Tax. The County Manager of Franklin County entered into an agreement with the Commissioner of Motor Vehicles for the collection of the tax in accordance with the provisions of this Part, for the collection of such tax on original registrations made on and after March 1, 2012 and upon the renewal of registrations expiring on and after May 1, 2012. The County Treasurer is the appropriate fiscal officer, except that the County Attorney is the appropriate legal officer of Franklin County referred to in this Part. The tax due on passenger motor vehicles for which the registration fee is established in paragraph (a) of subdivision (6) of Section 401 of the Vehicle and Traffic Law shall be \$5.00 per annum on such motor vehicles weighing 3500 lbs. or less and \$10.00 per annum for such motor vehicles weighing in excess of 3500 lbs. The tax due on trucks, buses and other commercial motor vehicles for which the registration fee is established in subdivision (7) of Section 401 of the Vehicle and Traffic Law used principally in connection with a business carried on within Franklin County, except for vehicles used in connection with the operation of a farm by the owner or tenant thereof shall be \$10.00 per annum.*

Text of proposed rule and any required statements and analyses may be obtained from: Heidi Bazicki, Department of Motor Vehicles, 6 Empire State Plaza, Rm. 526, Albany, NY 12228, (518) 474-0871, email: heidi.bazicki@dmv.state.ny.us

Data, views or arguments may be submitted to: Ida Traschen, Department of Motor Vehicles, Same, (518) 474-0871, email: heidi.bazicki@dmv.state.ny.us

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

Consensus Rule Making Determination

This proposed regulation would create a new 15 NYCRR Part 29.12(ai) to provide for the collection of a Franklin County motor vehicle use tax by the Department of Motor Vehicles. Pursuant to the authority contained in Tax Law section 1202(c) and Vehicle and Traffic Law section 401(6)(d)(ii), the Commissioner must collect a motor vehicle use tax if a county has enacted a local law requiring the collection of such tax.

On September 15, 2011, the Franklin County Legislature enacted a resolution requiring that a motor vehicle use tax be imposed on passenger and commercial vehicles. Pursuant to this resolution, the Commissioner is required to collect the tax on behalf of the county and transmit the revenue to the County, minus the administrative costs required to process the tax. The tax is five dollars per annum on a passenger vehicle weighing 3,500 pounds or less, ten dollars per annum on a passenger vehicle weighing more than 3,500 pounds, and ten dollars per annum on all commercial vehicles. There are certain exempt vehicles, such as vehicles used by non-profit religious, charitable, or educational organizations, and vehicles used only in connection with the operation of a farm by the owner or tenant of the farm.

This is a consensus rule because the Commissioner has no discretion about whether to collect the tax, i.e., it must be collected per the mandate

of the Franklin County resolution. The merits of the tax may have been debated before the Franklin County Legislature, but are no longer the subject of debate-it is now the law. DMV is merely carrying out the will expressed by the County Legislature.

Job Impact Statement

A Job Impact Statement is not submitted with this rulemaking, because it will not have any impact on job creation or development in New York State.

Office for People with Developmental Disabilities

NOTICE OF ADOPTION

Provider Allocation of OPWDD Funding

I.D. No. PDD-42-11-00008-A

Filing No. 1337

Filing Date: 2011-12-12

Effective Date: 2011-12-28

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

Action taken: Amendment of sections 635-10.5, 671.7 and 681.14 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 13.09(b) and 43.02

Subject: Provider allocation of OPWDD funding.

Purpose: To repeal a provision that restricts providers' abilities to allocate revenues to administrative expense.

Text or summary was published in the October 19, 2011 issue of the Register, I.D. No. PDD-42-11-00008-EP.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 12229, (518) 474-1830, email: barbara.brundage@opwdd.ny.gov

Additional matter required by statute: Pursuant to the requirements of the State Environmental Quality Review Act, OPWDD, as lead agency, has determined that the action described herein will have no effect on the environment, and an E.I.S. is not needed.

Assessment of Public Comment

The agency received no public comment.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Behavior Management - Modifying or Controlling Maladaptive or Inappropriate Behavior

I.D. No. PDD-52-11-00020-P

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

Proposed Action: Addition of section 633.16; and amendment of Parts 81, 624, 633 and 681 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 13.07, 13.09 and 16.00

Subject: Behavior Management - Modifying or controlling maladaptive or inappropriate behavior.

Purpose: To establish requirements for interventions used in the OPWDD system to modify or control maladaptive or inappropriate behavior.

Substance of proposed rule (Full text is posted at the following State website: www.opwdd.ny.gov): The proposed regulations establish new requirements concerning behavior management in the OPWDD system. OPWDD is proposing the addition of a new 14NYCRR Section 633.16, which contains comprehensive requirements for the management of maladaptive or inappropriate behavior. These new requirements will help agencies provide high quality services, and will protect the rights and welfare of individuals receiving services.

The new Section 633.16 contains a number of provisions to protect the

health, safety and rights of individuals who engage in maladaptive or inappropriate behaviors. Among the provisions of Section 633.16 are the following:

- Aversive conditioning is prohibited.
- Agencies must conduct a functional behavioral assessment to obtain relevant information for effective intervention planning before a behavior support plan is developed to address maladaptive or inappropriate behavior. Specific components must be addressed or included in the functional behavioral assessment.
- Behavior support plans must be developed that are specific to each person who exhibits maladaptive or inappropriate behavior. These plans specify the interventions that may be used. The regulations establish a number of components that must be included in the plan. Among the specific required components of behavior support plans is the inclusion of a hierarchy of behavioral approaches, strategies, and supports to address the behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
- Additional safeguards are established for plans that contain "restrictive/intrusive interventions" or limitations on a person's rights. "Restrictive/intrusive interventions" are defined in the regulation and include specific behavioral interventions such as "intermediate" and "restrictive" physical intervention techniques (hands-on techniques), use of "time-out," use of mechanical restraining devices, and use of medication to modify or control maladaptive or inappropriate behavior or treat a co-occurring diagnosed psychiatric condition.
- Safeguards and protections related to restrictive/intrusive interventions and limitations on a person's rights include:
- Additional components must be included in the person's behavior support plan. Plans must be developed by a licensed psychologist or applied behavior sciences specialist (who has at least a Master's degree and meets specified qualifications).
- Plans must be reviewed and sanctioned before implementation by a behavior management/human rights committee. Required membership and procedures for these committees are established. (The requirement for committee review does not apply to plans that include medication to treat a co-occurring diagnosed psychiatric condition. The regulations describe standards for determining what constitutes a "psychiatric condition.")
- Informed consent is required for the use of restrictive/intrusive interventions. Procedures are established to determine whether the person receiving services is capable of providing informed consent. If an individual is not capable of providing informed consent, procedures are established for obtaining informed consent from designated surrogate decision makers (e.g. actively involved parents and actively involved family members). In the event that no other surrogate is reasonably available and willing, consent can be sought from the Willowbrook Consumer Advisory Board or an informed consent committee. Required membership and procedures are established for the informed consent committee. Consent can also be obtained from a court.
- Procedures are established for objecting to behavior support plans and addressing a lack of informed consent. Procedures are also established concerning refusal of the individual receiving services to take medication.
- Requirements are included for training of staff, family care providers and respite substitute providers.
- Additional safeguards are established for the use of physical intervention techniques (hands-on techniques). Physical intervention techniques are categorized as protective, intermediate or restrictive. Among these safeguards are requirements for training and certification in the use of the techniques.
- Additional safeguards are established for the limitations on a person's rights.
- Additional safeguards are established for the use of "time-out." "Time-out" includes both exclusionary time-out (placing a person in a specific time-out room), and non-exclusionary time-out (removing the positively reinforcing environment from the individual). Environmental requirements are established for time-out rooms.
- Additional safeguards are established for the use of mechanical restraining devices.
- Additional safeguards are established for the use of medication to modify or control maladaptive or inappropriate behavior. This includes the use of medication to treat co-occurring diagnosed psychiatric conditions.
- The regulations specify that restrictive/intrusive interventions cannot be used in an emergency, except for intermediate and restrictive physical intervention techniques and the use of medication. Limitations on a person's rights can also be used in an emergency.

- Provisions are established for phasing-in the requirements. Requirements for new behavior support plans (and associated informed consent) are applied 45 days after the regulation becomes effective, and requirements for existing plans (and associated informed consent) are applied a year after that. This will enable agencies to apply the new development standards to existing behavior support plans during regularly scheduled reviews.

The regulation also amends 14NYCRR Section 681.13, which contains requirements applicable to behavior management in ICF/DD facilities. The provisions of this section address many of the same issues that are addressed in Section 633.16. The amendments to Section 681.13 phase out the requirements of that section in conjunction with the phase-in of the requirements of the new Section 633.16. Once Section 633.16 is fully phased in, Section 681.13 will no longer be effective. Outdated and duplicative requirements in Part 81 are deleted.

14NYCRR Part 624 is amended so that new definitions of categories of abuse become effective once Section 633.16 is fully phased in. These new definitions conform to Section 633.16 so that if interventions are used which are not in accordance with the requirements of the new section, their use is considered to be abuse (unless actions were taken that were necessary to address an immediate risk to the health or safety of the person or others). Definitions in the glossary of Part 624 are also changed to conform to the new definitions in Section 633.16.

14NYCRR Part 633 is amended to enhance protections related to limiting the rights of a person receiving services and to conform to protections related to limitation of rights in the new Section 633.16. Definitions in Section 633.99 are also changed to conform to the new definitions used in Section 633.16.

Text of proposed rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 12229, (518) 474-1830, email: barbara.brundage@opwdd.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.

Additional matter required by statute: Pursuant to the requirements of the State Environmental Quality Review Act, OPWDD, as lead agency, has determined that the action described herein will have no effect on the environment, and an E.I.S. is not needed.

Regulatory Impact Statement

1. Statutory Authority:

a. OPWDD has the statutory responsibility to provide and encourage the provision of appropriate programs and services in the area of care, treatment, rehabilitation, education and training of persons with developmental disabilities, as stated in the New York State Mental Hygiene Law Section 13.07.

b. OPWDD has the statutory authority to adopt rules and regulations necessary and proper to implement any matter under its jurisdiction as stated in the New York State Mental Hygiene Law Section 13.09(b).

c. OPWDD has the statutory authority to adopt regulations concerning the operation of programs, provision of services and facilities pursuant to the New York State Mental Hygiene Law Section 16.00.

2. Legislative Objectives: These proposed amendments further the legislative objectives embodied in sections 13.07, 13.09(b), and 16.00 of the Mental Hygiene Law. The proposed amendments would improve the quality of services in the OPWDD system by establishing protections for individuals with maladaptive or inappropriate behaviors.

3. Needs and Benefits: The management of maladaptive or inappropriate behaviors is an important component of the OPWDD system. Managing behavior appropriately can significantly enrich the lives of individuals with developmental disabilities and enable them to become more independent and successful in many aspects of their lives. Further, poor behavior management practices can have tragic consequences and have been a contributing factor in serious injuries and deaths in the OPWDD system.

OPWDD is proposing the addition of a new section containing comprehensive requirements for the management of maladaptive and inappropriate behavior. These new requirements will help agencies provide higher quality services and will protect the rights and welfare of individuals receiving services.

The regulation emphasizes that positive approaches, strategies and supports are always the preferred method of managing maladaptive or inappropriate behavior. In addition, the regulation establishes specific procedures that must be followed in order to safeguard the use of specific behavioral interventions that limit rights or have potential adverse impacts.

The implementation of the new provisions would require that agencies incur additional expenses and redirect existing staff resources toward compliance activities. OPWDD considers that the additional costs and staff time involved are more than justified by the enhanced protections afforded to individuals receiving services. Further, OPWDD is phasing-in

the new requirements so that agencies will have adequate time to hire the necessary staff and integrate the new required processes into existing agency procedures. OPWDD has also delayed the imposition of the new planning requirements on existing behavior support plans so that the new requirements can be implemented during regularly scheduled reviews of the current plans.

Among its provisions, the proposed regulations prohibit aversive conditioning. OPWDD considers that the use of behavior modification techniques that involve deliberately inflicting sensations that are uncomfortable, painful or noxious is inappropriate and unnecessary.

The regulations also modify the definitions of abuse in Part 624 to conform to the provisions of the new behavior management requirements and add additional clarity.

The provisions of Section 681.13 are phased out in conjunction with the phase-in of the new Section 633.16. These provisions contain requirements for behavior management in Intermediate Care Facilities (ICF/DDs). Since ICF/DDs are required to comply with the provisions of Section 633.16 concerning behavior management, these requirements are duplicative and are therefore being phased out.

Outdated and duplicative requirements contained in Part 81 which concerned review of "untoward incidents" and "extra risk procedures" in "Schools for the Mentally Retarded" have been deleted. These areas are addressed in Part 624 and the new Section 633.16.

4. Costs:

a. Costs to the Agency and to the State and its local governments: There are no anticipated impacts on Medicaid rates, prices or fees. Consequently, there is no impact on the federal government, New York State or local governments due to changes in Medicaid expenditures. As a provider of services, OPWDD will need to redirect staff resources to compliance activities required by the proposed regulations. State-operated services have already instituted many of the new required procedures and OPWDD expects that the enhanced requirements in the proposed regulations can be implemented with existing staff in state-operated services. Consequently, OPWDD does not expect to incur any additional costs.

b. Costs to private regulated parties: There are no initial capital investment costs. There may be initial non-capital expenses related to the costs of hiring or retaining new psychologists, applied behavioral sciences specialists and other clinicians. OPWDD estimates that the aggregate annual expense for agencies to hire or retain the necessary clinicians will be approximately \$10.1 million.

5. Local Governmental Mandates: There are no new requirements imposed by the rule on any county, city, town, village; or school, fire, or other special district.

6. Paperwork: The regulation includes significant new paperwork requirements. For example, it requires the development of policies and procedures and written behavior support plans for individuals who have maladaptive or inappropriate behavior which address a number of specific elements, including a functional behavioral assessment. The regulation also requires documentation of the individual's behavior and use of behavioral interventions. In some instances, the use of behavioral interventions must be reported to OPWDD. The regulation requires training, which would involve the dissemination of training materials and documentation of training. In some cases, these requirements can be met through electronic reporting and record-keeping. OPWDD considers that the increased paperwork is justified by the need for additional protections for individuals receiving services concerning behavior management.

7. Duplication: The proposed amendments do not duplicate any existing State or Federal requirements that are applicable to services for persons with developmental disabilities. The proposed amendments include the repeal of specific requirements in OPWDD regulations that govern behavior management in Intermediate Care Facilities (ICF/DDs), since those requirements would have been duplicative.

8. Alternatives: OPWDD considered applying all regulatory requirements imposed for restrictive/intrusive interventions to medications used to treat a diagnosed mental illness. However, upon reflection, OPWDD determined that that not all requirements were necessary to safeguard individuals who are prescribed these medications. The requirement for review by the behavior management/human rights committee was consequently removed.

9. Federal Standards: The proposed amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance Schedule: OPWDD plans to promulgate these regulations as soon as possible within the timeframes established by the State Administrative Procedure Act. OPWDD may delay the effective date of the regulation to accommodate the need for agencies to hire staff (especially psychologists and applied behavioral sciences specialists), and for other changes necessary for agencies to come into compliance, such as training staff, establishing the required committees, and changing policies and procedures. The proposed regulation incorporates delays in the

timeframe for implementation after the effective date for specific requirements that necessitate a more involved level of compliance activities. In addition, requirements applicable to the development of behavior support plans and obtaining informed consent will be phased in so that existing behavior support plans can be revised at the time of regularly scheduled reviews. Delays in the timeframe for implementation of the conforming changes have also been incorporated for consistency during the transition.

Regulatory Flexibility Analysis

1. Effect on Small Business: OPWDD has determined, through a review of the certified cost reports, that most OPWDD-funded services are provided by non-profit agencies which employ more than 100 people overall. However, some smaller agencies which employ fewer than 100 employees overall would be classified as small businesses. Currently, there are 670 agencies which provide one or more of the facilities and services which are required to comply with the proposed regulations. These are agencies which operate any facility certified by OPWDD (except for free-standing respite facilities and clinics), which provide day habilitation or prevocational services regardless of whether the services are certified, and/or which provide hourly community habilitation. OPWDD is unable to estimate the portion of these providers that may be considered to be small businesses.

The proposed regulations impose significant compliance requirements on these providers, if they serve individuals with maladaptive or inappropriate behaviors. Many agencies have current policies which incorporate some of these requirements; however, in nearly all instances agencies will need to institute or enhance current policies and procedures related to behavior management.

2. Compliance Requirements: Specific compliance requirements imposed on providers (including small businesses) by the proposed regulations include: the development of policies/procedures, conducting functional behavioral assessments, developing behavior support plans (including reviews and updates), convening a behavior management/human rights committee, documenting the work of the committee and use of behavioral interventions, obtaining informed consent for "restrictive/intrusive interventions," training staff in the use of specific interventions, training staff in the use of "physical intervention techniques" (hands-on techniques), reporting the use of restrictive physical interventions to OPWDD, and complying with a number of requirements applicable to specific interventions (physical intervention techniques, rights limitations, use of "time-out," use of mechanical restraining devices, and use of medication to modify or control maladaptive or inappropriate behavior or to treat a diagnosed mental illness). The provider is also required to document these activities.

The proposed regulations have no impact on local governments.

3. Professional Services: The proposed regulations specify certain functions that must be performed by clinicians, such as the development of behavior support plans and evaluation of the capacity of individuals to provide informed consent in some circumstances. Various functions are required to be performed by licensed psychologists and/or applied behavior sciences specialists (ABSS) (which have a Master's degree) and/or clinicians with training in behavior management techniques. In addition, the regulation requires the supervision of ABSS by a licensed psychologist which may mean that the supervising licensed psychologist must be hired or retained. Although many agencies already employ or retain these professionals, and in some instances the clinicians already perform some or many of the functions that will be required, OPWDD expects that some agencies will need to hire more of these clinicians to comply with the new requirements or make arrangements for their services.

Certain functions specified by the proposed regulation require the involvement of health care professionals. While OPWDD generally expects that agencies will be able to comply using existing staff who are health care professionals, in some instances agencies may need to hire or increase arrangements for contractors or consultants who are clinicians or other professionals to satisfy these requirements.

The proposed regulations will not add to the professional service needs of local governments.

4. Compliance Costs: No increased capital costs will be incurred. Some agencies will incur costs to hire or arrange for clinicians as discussed above. OPWDD estimates that the aggregate annual expense for agencies to hire or retain the necessary clinicians will be approximately \$10.1 million.

5. Economic and Technological Feasibility: The proposed amendments do not impose on regulated parties the use of any new technological processes.

6. Minimizing Adverse Impact: In general, individuals with more significant maladaptive or inappropriate behaviors are served by agencies which are not small businesses. Further, the development of policies and procedures are only required for agencies which serve individuals in need of behavior support plans. Smaller providers which do not serve individu-

als in need of behavior support plans will not need to undertake any of the compliance activities, including the development of agency policies and procedures. OPWDD expects that even if small providers serve individuals who need behavior support plans, that the plans will typically be less complex and will typically not include "restrictive/intrusive interventions" (except for the use of medication to treat a diagnosed mental illness) and that the agencies can consequently forgo compliance with many of the specific provisions applicable to those interventions. OPWDD has specifically exempted use of medication to treat a diagnosed mental illness from review by a behavior management/human rights committee, recognizing that small business providers are more likely to serve these individuals than individuals who need medication or other interventions to address maladaptive or inappropriate behavior and thereby offering some relief to small providers. Further, OPWDD recognizes that it could be difficult for each smaller agency to convene the required behavior management/human rights committee. The regulations specifically allow agencies to coordinate with other agencies in the creation of a shared behavior management/human rights committee.

7. Small Business Participation: The proposed regulations were discussed with representatives of providers, including the New York State Association of Community and Residential Agencies (NYSACRA), at several meetings. In addition, draft proposed regulations were sent to selected reviewers in October 2011, including NYSACRA and other provider associations. Some of the members of NYSACRA have fewer than 100 employees. Finally, OPWDD will be mailing these proposed amendments to all providers, including providers that are small businesses.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: OPWDD services are provided in every county in New York State. 44 counties have a population less than 200,000: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates. 9 counties with certain townships have a population density of 150 persons or less per square mile: Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga and Orange.

The proposed amendments have been reviewed by OPWDD in light of their impact on entities in rural areas. The proposed amendments are expected to result in additional expenditures of approximately \$10.1 million for non-state providers of services in the OPWDD system for all of New York State. While the additional requirement will have an adverse fiscal impact on providers, the geographic location of any given program (urban or rural) will not be a contributing factor to any such impact.

2. Compliance requirements: Specific compliance requirements imposed on providers (including small businesses) by the proposed regulations include: the development of policies/procedures, conducting functional behavioral assessments, developing behavior support plans (including reviews and updates), convening a behavior management/human rights committee, documenting the work of the committee and use of behavioral interventions, obtaining informed consent for "restrictive/intrusive interventions," training staff in the use of specific interventions, training staff in the use of "physical intervention techniques" (hands-on techniques), reporting the use of restrictive physical interventions to OPWDD, and complying with a number of requirements applicable to specific interventions (physical intervention techniques, rights limitations, use of "time-out," use of mechanical restraining devices, and use of medication to modify or control maladaptive or inappropriate behavior or to treat a diagnosed mental illness). The provider is also required to document these activities.

The proposed regulations have no impact on local governments.

3. Professional services: The proposed regulations specify certain functions that must be performed by clinicians, such as the development of behavior support plans and evaluation of the capacity of individuals to provide informed consent in some circumstances. Various functions are required to be performed by licensed psychologists and/or applied behavior sciences specialists (ABSS) (which have a Master's degree) and/or clinicians with training in behavior management techniques. In addition, the regulation requires the supervision of ABSS by a licensed psychologist which may mean that the supervising licensed psychologist must be hired or retained. Although many agencies already employ or retain these professionals, and in some instances the clinicians already perform some or many of the functions that will be required, OPWDD expects that some agencies will need to hire more of these clinicians to comply with the new requirements or make arrangements for their services.

Other regulatory requirements require the involvement of health care professionals. While OPWDD generally expects that agencies will be able

to comply using existing staff, in some instances agencies may need to hire or increase arrangements for contractors or consultants who are clinicians or other professionals to satisfy these requirements.

The proposed regulations will not add to the professional service needs of local governments.

4. Compliance costs: The estimated cost of compliance is \$10.1 million for all voluntary providers statewide (not just those in rural areas). There are no costs to local governments.

5. Minimizing adverse economic impact: OPWDD has reviewed and considered the approaches for minimizing adverse economic impact as suggested in section 202-bb(2)(b) of the State Administrative Procedure Act. OPWDD recognizes that agencies in rural areas are generally smaller in size than agencies in general. The economic impact of the proposed regulations is attributable to the need for additional clinicians, especially licensed psychologists and applied behavioral sciences specialists. Smaller providers which do not serve individuals in need of behavior support plans will not need to undertake any of the compliance activities, including the work that would need to be performed by these clinicians. OPWDD expects that even if small providers serve individuals who need behavior support plans, that the plans will typically be less complex and will typically not include "restrictive/intrusive interventions" (except for the use of medication to treat a diagnosed mental illness) and that the agencies can consequently forgo compliance with many of the specific provisions applicable to those interventions. OPWDD has specifically exempted use of medication to treat a diagnosed mental illness from review by a behavior management/human rights committee, recognizing that small business providers are more likely to serve these individuals than individuals who need medication or other interventions to address maladaptive or inappropriate behavior and thereby offering some relief to small providers. Further, OPWDD recognizes that it could be difficult for each smaller agency to convene the required behavior management/human rights committee. The regulations specifically allow agencies to coordinate with other agencies in the creation of a shared behavior management/human rights committee.

6. Participation of public and private interests in rural areas: The proposed regulations were discussed with representatives of providers at several meetings. In addition, draft proposed regulations were sent to selected reviewers in October 2011, including provider associations. Provider associations which were present, such as NYSARC, the NYS Association of Community and Residential Agencies, NYS Catholic Conference, and CP Association of NYS, represent providers throughout New York State including those in rural areas. OWPDD will be mailing these amendments to all providers, including providers that are located in rural areas.

Job Impact Statement

A Job Impact Statement for these proposed amendments is not being submitted because OPWDD does not anticipate a substantial adverse impact on jobs and employment opportunities. The proposed amendments require agencies to institute new protections for individuals related to behavior management. As noted in the other impact statements, there may be a modest increase in job opportunities for clinicians, especially psychologists, as a result of these amendments.

Public Service Commission

**PROPOSED RULE MAKING
HEARING(S) SCHEDULED**

Major Electric Rate Filing

I.D. No. PSC-52-11-00012-P

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

Proposed Action: The Commission is considering a proposal filed by Pennsylvania Electric Company to make various changes in the rates, charges, rules and regulations contained in its Schedule for Electric Service—P.S.C. No. 6—Electricity.

Statutory authority: Public Service Law, section 66(12)

Subject: Major electric rate filing.

Purpose: To consider a proposal to increase annual electric revenues.

Public hearing(s) will be held at: 10:30 a.m., March 26, 2012 and continuing daily as needed* at Department of Public Service, Three Empire State Plaza, 3rd Fl. Hearing Rm., Albany, NY.

*On occasion, there are requests to reschedule or postpone evidentiary hearing dates. If such a request is granted, notification of any subsequent scheduling changes will be available at the DPS website (www.dps.ny.gov) under Case 11-E-0594.

Interpreter Service: Interpreter services will be made available to hearing impaired persons, at no charge, upon written request submitted within reasonable time prior to the scheduled public hearing. The written request must be addressed to the agency representative designated in the paragraph below.

Accessibility: All public hearings have been scheduled at places reasonably accessible to persons with a mobility impairment.

Substance of proposed rule: The Commission is considering a proposal filed by the Pennsylvania Electric Company (Penelec or the Company) to increase rates for its customers in Waverly, New York. Penelec is requesting an increase in total revenues of about \$2.0 million or 42%. The increase is primarily based on Waverly customers being charged the same market based commodity rates that will be charged to all other Penelec customers on July 1, 2012. The proposed increase is based on the commodity rate currently charged in Pennsylvania, not on a 2012 forecast. The increase is also due to new Federal Energy Regulatory Commission approved transmission rates, higher non-utility generator costs and the New York State Temporary Assessment. Delivery rates are not being increased. Penelec is proposing a three year phase-in of about 15% for Year One and 10%, respectively, for Years Two and Three. The statutory suspension period for the proposed filing runs through September 25, 2012. The Commission may adopt, in whole or in part, modify or reject terms set forth in Penelec's proposal, a three-year rate plan, or other negotiated proposals.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillig, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0594SP1)

**PROPOSED RULE MAKING
HEARING(S) SCHEDULED**

Reparations and Refunds

I.D. No. PSC-52-11-00017-P

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

Proposed Action: The Commission is considering whether to approve or reject a request by KeySpan Gas East Corporation d/b/a National Grid proposed disposition of a property tax refund.

Statutory authority: Public Service Law, section 113(2)

Subject: Reparations and refunds.

Purpose: Reparations and refunds.

Public hearing(s) will be held at: 1:00 p.m., Feb. 14, 2012* at Department of Public Service, Three Empire State Plaza, 3rd Fl. Hearing Rm., Albany, NY.

*On occasion there are requests to reschedule or postpone evidentiary hearing dates. If such a request is granted, notification of any subsequent scheduling changes will be available at the DPS website (www.dps.ny.gov) under Case 11-M-0601.

Interpreter Service: Interpreter services will be made available to hearing impaired persons, at no charge, upon written request submitted within reasonable time prior to the scheduled public hearing. The written request must be addressed to the agency representative designated in the paragraph below.

Accessibility: All public hearings have been scheduled at places reasonably accessible to persons with a mobility impairment.

Substance of proposed rule: The Public Service Commission is considering a petition by KeySpan Gas East Corporation d/b/a National Grid

(Company/KeySpan) to implement its proposed disposition of a property tax refund. The Commission may approve, reject or modify, in whole or in part, the relief requested by KeySpan.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-G-0601SP1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Transfer of Ownership of Electric Interconnection Facilities from Sheldon to NYSEG

I.D. No. PSC-52-11-00009-P

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

Proposed Action: The Commission is considering a petition requesting the approval of the transfer of electric interconnection facilities from Sheldon Energy LLC (Sheldon) to New York State Electric & Gas Corporation (NYSEG).

Statutory authority: Public Service Law, sections 2(11), 5(1)(b) and 70

Subject: Transfer of ownership of electric interconnection facilities from Sheldon to NYSEG.

Purpose: Consideration of the transfer of ownership of electric interconnection facilities from Sheldon to NYSEG.

Substance of proposed rule: The Public Service Commission is considering a petition filed on November 10, 2011 requesting approval of the transfer, from Sheldon Energy LLC to New York State Electric & Gas Corporation, of ownership interests in electric interconnection facilities, consisting of a 34.5 kV to 230 kV substation connected via an overhead bus to an adjacent 230 kV Switchyard, that connect the High Sheldon Wind Farm located in Wyoming County, New York, to the electric transmission system. The Commission may adopt, reject or modify, in whole or in part, the relief proposed.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann.ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0619SP1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

New York State Reliability Council's Establishment of an Installed Reserve Margin of 16.0%

I.D. No. PSC-52-11-00010-P

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

Proposed Action: The Commission is considering whether to adopt, modify, or reject, in whole or in part, an Installed Reserve Margin of 16.0% established by the New York State Reliability Council for the Capability Year beginning May 1, 2012, and ending April 30, 2013.

Statutory authority: Public Service Law, sections 4(1), 5(2), 65(1), 66(1), (2), (4) and (5)

Subject: New York State Reliability Council's establishment of an Installed Reserve Margin of 16.0%.

Purpose: To adopt an Installed Reserve Margin for the Capability Year beginning May 1, 2012, and ending April 30, 2013.

Substance of proposed rule: The Public Service Commission (PSC) is considering whether to adopt, modify, or reject, in whole or in part, an Installed Reserve Margin (IRM) of 16.0% established by the New York State Reliability Council for the Capability Year beginning May 1, 2013, and ending April 30, 2013. The IRM is based on the Technical Study Report entitled "New York Control Area Installed Capacity Requirements For The Period May 2012 Through April 2013" (Report). The Report is available on the internet at: http://www.nysrc.org/NYSRC_NYCA_ICR_Reports.asp

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann.ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(07-E-0088SP6)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Modification of NYSEG and RG&E's Arrears Forgiveness Component of the Companies' Low Income Program

I.D. No. PSC-52-11-00011-P

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

Proposed Action: The Commission is considering a filing from New York State Electric and Gas Corporation (NYSEG) and Rochester Gas and Electric Corporation (RG&E) proposing modifications of the arrears forgiveness component of the companies' low income program.

Statutory authority: Public Service Law, sections 5(1)(b), 65(1), (2), (3), 66(1), (3), (5), (10) and (12)

Subject: Modification of NYSEG and RG&E's arrears forgiveness component of the companies' low income program.

Purpose: Consideration of modification of NYSEG and RG&E's arrears forgiveness component of the companies' low income program.

Substance of proposed rule: The Commission is considering a filing from New York State Electric and Gas Corporation (NYSEG) and Rochester Gas and Electric Corporation (RG&E) made on December 6, 2011 proposing modifications to the arrears forgiveness component of the companies' low income program. The Commission may adopt, reject or modify, in whole or in part, the relief proposed.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(09-E-0715SP3)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Request Authorization to Defer Incremental Expenses Incurred in Storm Restoration Work

I.D. No. PSC-52-11-00013-P

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

Proposed Action: The PSC is considering a petition filed by Central Hudson Gas & Electric Corporation seeking authority to defer incremental electric storm restoration expenses incurred related to Tropical Storm Irene on August 27-28, 2011.

Statutory authority: Public Service Law, section 66(9)

Subject: Request authorization to defer incremental expenses incurred in storm restoration work.

Purpose: To allow the company to defer incremental expenses incurred in storm restoration work.

Substance of proposed rule: Central Hudson Gas & Electric Corporation (Central Hudson or Company) has requested permission to defer for future rate recovery, with carrying charges, \$11.4 million in incremental electric storm restoration expense related to Tropical Storm Irene on August 27-28, 2011. The Company proposes to defer such expenses and the associated deferred income taxes as a regulatory asset in Account 182.xx. If the Commission approves this deferral, there is a reasonable assurance the company will be allowed to recover these costs. The Commission may adopt, reject or modify, in whole or in part, Central Hudson's request, and may also consider any related matters.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0651SP1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Transition Charge

I.D. No. PSC-52-11-00014-P

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

Proposed Action: The Commission is considering a proposed tariff filing by New York State Electric & Gas Corporation to revise its tariff schedule, P.S.C. No. 120—Electricity.

Statutory authority: Public Service Law, section 66(12)

Subject: Transition Charge.

Purpose: To revise its tariff schedule for calculating the Transition Charge.

Substance of proposed rule: The Commission is considering whether to approve, modify or reject, in whole or in part, a tariff filing by New York State Electric & Gas Corporation to revise its tariff for calculating the Transition Charge to refund to customers any payments received under a Revenue Sharing Agreement. The proposed filing has an effective date of March 1, 2012. The Commission may apply aspects of its decision here to the requirements for tariffs of other utilities.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0669SP1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Transition Charge

I.D. No. PSC-52-11-00015-P

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

Proposed Action: The Commission is considering a proposed tariff filing by Rochester Gas and Electric Corporation to revise its tariff schedule, P.S.C. No. 19—Electricity.

Statutory authority: Public Service Law, section 66(12)

Subject: Transition Charge.

Purpose: To revise its tariff schedule for calculating the Transition Charge.

Substance of proposed rule: The Commission is considering whether to approve, modify or reject, in whole or in part, a tariff filing by Rochester Gas and Electric Corporation to revise its tariff for calculating the Transition Charge to refund to customers any payments received under a Revenue Sharing Agreement. The proposed filing has an effective date of March 1, 2012. The Commission may apply aspects of its decision here to the requirements for tariffs of other utilities.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0670SP1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Transfer of Ownership Interests in an 80 MW Generation Facility from Rensselaer Holdings to LDHE

I.D. No. PSC-52-11-00016-P

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

Proposed Action: The Commission is considering approval of the transfer, from Rensselaer Holdings LLC (Rensselaer Holdings) to Louis Dreyfus Highbridge Energy LLC (LDHE), of ownership interests in Rensselaer Cogeneration LLC and its 80 MW generation facility.

Statutory authority: Public Service Law, sections 2(11), 5(1)(b) and 70

Subject: Transfer of ownership interests in an 80 MW generation facility from Rensselaer Holdings to LDHE.

Purpose: Consideration of the transfer of ownership interests in an 80 MW generation facility from Rensselaer Holdings to LDHE.

Substance of proposed rule: The Public Service Commission is considering a petition filed on December 5, 2011 requesting approval of the transfer, from Rensselaer Holdings LLC to Louis Dreyfus Highbridge Energy LLC, of all of the ownership interests in Rensselaer Cogeneration

LLC, which owns and operates an 80 MW gas-fired generation facility located Rensselaer, NY. The Commission may adopt, reject or modify, in whole or in part, the relief proposed.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann.ayer@dps.ny.gov

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: secretary@dps.ny.gov

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

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

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(11-E-0663SP1)

Racing and Wagering Board

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Authorizing and Prohibiting the Use of Phenylbutazone, or “Bute”

I.D. No. RWB-52-11-00007-P

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

Proposed Action: Amendment of sections 4043.2(d) and 4120.2(d) of Title 9 NYCRR.

Statutory authority: Racing, Pari-Mutuel Wagering and Breeding Law, sections 101(1), 301(2)(a) and 902(1)

Subject: Authorizing and prohibiting the use of phenylbutazone, or “bute.”

Purpose: To make bute a 48-hour drug only (vice 24- and 48-hour) in both harness and thoroughbred racing.

Text of proposed rule: Subdivision (d) of Section 4043.2 of 9 NYCRR is amended to read as follows:

(d) [Either one, but no more than one, of the]The following [two] non-steroidal anti-inflammatory drug[s] may be administered by intravenous injection until 24 hours before the scheduled post time of the race in which the horse is to compete[.]:

[(1)] flunixin[.];

[(2)] phenylbutazone.]

Subdivision (d) of Section 4120.2 of 9 NYCRR is amended to read as follows:

(d) [Either one, but no more than one, of the] The following [two] non-steroidal anti-inflammatory drug[s] may be administered by intravenous injection until 24 hours before the scheduled post time of the race in which the horse is to compete[.]:

[(1)] flunixin[.];

[(2)] phenylbutazone.]

Text of proposed rule and any required statements and analyses may be obtained from: John J. Googas, New York State Racing and Wagering Board, One Broadway Center, Suite 600, Schenectady, New York 12305-2553, (518) 395-5400, email: info@racing.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.

Regulatory Impact Statement

1. Statutory authority: Racing, Pari-Mutuel and Breeding Law, sections 101 and 902, authorizes the New York State Racing and Wagering Board (“Board”) to prescribe and promulgate regulations to specify the use and testing of drugs and substances in thoroughbred

and harness race horses. Racing, Pari-Mutuel and Breeding Law sections 301 directs the Board to prescribe rules and regulations for the administration of drugs to harness horses and quarterhorses, respectively for the purpose of affecting the speed of such horses.

2. Legislative objectives: To enable the Board to assure the public’s confidence and preserve the high degree of integrity of racing at pari-mutuel betting tracks by regulating the use of drugs and medications in race horses so that the horses are fit and healthy, but not running on substances that have the potential to affect the outcome of a given race.

3. Needs and benefits: This rule is necessary to ensure that horses are not overmedicated to the point of adversely affecting the integrity of horseracing, and after a five-year period, the Board believes that a previous 48-rule phenylbutazone administration rule is more appropriate than one adopted in 2005. Furthermore, as of Jan. 1, 2012, the American Graded Stakes Committee will require races to be run at the lower level (48 hours, 2 micrograms per milliliter testing level) in order for New York State thoroughbred racing to maintain grade eligibility.

Phenylbutazone, commonly known as “Bute,” is a non-steroidal anti-inflammatory drug used in racehorses. On or before 1971 to 2005, the administration of Bute was not permitted less than 48 hours before races in New York. There were few post-race positives during that 30 year period.

Prompted by an effort of the Mid-Atlantic Consortium of Racing States to achieve regional uniformity, the Board adopted a rule to allow Bute as a 24-hour drug effective January 4, 2006. Among the benefits sought was to create consistency throughout the racing states so that veterinarians could have a certain threshold under which they could provide therapeutic treatment.

Since 2006, the Mid-Atlantic States have embraced the Board’s original 48-hour rule. In addition, the RMTTC has revisited the matter and now recommends that the permitted Bute levels return to New York’s pre-2006 levels. Accordingly, the Board’s proposed rule would return to the longstanding, time-tested, and familiar New York practice of restricting the administration of Bute to 48 hours. The Board and industry have considerable experience with banning Bute for 48 hours as a result of this being our rule from 1971 through 2005. During those 30-plus years, there were virtually no post-race positives, or complaints about the rule from horsemen, or veterinary complaints about the care, treatment, health, or safety of our race horses.

Additionally, in 2010 the Association of Racing Commissioners International Model Rules Committee voted to lower the Bute threshold. This proposed rulemaking is consistent with that model rule.

Concerns that veterinarians will be restricted in their ability to treat a horse up to 24 hours before a race are minimized by the extensive experience in New York of more than 30 years of restricting Bute to 48 hours or more before a race, during which time there were virtually no complaints about the rule from veterinarians or horsemen about the care, treatment, health, or safety of the race horses.

4. Costs:

(i) There are no new or additional costs imposed by this rule upon regulated persons. The rule merely revises an existing rule in regards to allowable dosage of a medication.

(ii) There are no costs imposed upon the Racing and Wagering Board, the state or local government. The rule will be implemented using the Board’s existing regulatory and medication testing program. There will be no costs to local governments because they do not regulate pari-mutuel racing activities.

(iii) The Board has determined that no costs will be imposed based upon the fact that the rule does not create any new duty or obligation, utilizes an existing regulatory framework and medication testing program, and merely makes a quantitative modification to a medication rule.

(iv) Since the Board has determined that based upon the nature and subject of the amendment, the rule will not impose any new costs, the Board did not conduct an analysis of costs.

5. Paperwork: No new paperwork will be required. This rule will be implemented utilizing existing regulations and procedures.

6. Local government mandates: The supervision and regulation of pari-mutuel racing activities are the sole responsibility of the New York State Racing and Wagering Board, and do not involve local governments. Therefore, this rule will not impose any local government mandates.

7. Duplication: Since the New York State Racing and Wagering Board is exclusively responsible for the regulation of pari-mutuel racing activities in New York State, there are no other relevant rules or other legal requirements of the state or federal governments regarding the administration of furosemide to race horses.

8. Alternative approaches: The American Graded Stakes Committee requirement eliminates the adoption of any alternatives other than a 48-hour/2 microgram per milliliter testing threshold in thoroughbred racing. No other alternative was considered in light of the Board preferred course of action to specifically revert to the previous standard.

9. Federal standards: There are no federal standards applicable to the subject area of state-regulated pari-mutuel racing activities.

10. Compliance schedule: This rule will become effective upon filing as a Notice of Adoption with the New York State Department of State.

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

This proposal does not require a Regulatory Flexibility Statement, Jobs Impact Statement or Rural Area Flexibility Statement as the amendment merely removes the 24-hour rule allowing for the administration of the drug phenylbutazone to race horses. Phenylbutazone will still be allowed as a 48-hour drug, and the comparable drug flunixin is still allowed as a 24-hour drug. The rule is entirely limited to equine drug standards and testing, and merely modifies the restriction on administration of an approved drug for race horses. This rulemaking will not have a positive or negative impact on jobs. These amendments do not impact upon State Administrative Procedure Act § 102(8), nor do they affect employment. The proposal will not impose an adverse economic impact on reporting, recordkeeping or other compliance requirements on small businesses in rural or urban areas nor on employment opportunities. The rule does not impose any significant technological changes on the industry for the reasons set forth above.

Department of State

NOTICE OF ADOPTION

Uniform Standards of Professional Appraisal Practice

I.D. No. DOS-41-11-00001-A

Filing No. 1336

Filing Date: 2011-12-12

Effective Date: 2012-01-01

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

Action taken: Amendment of section 1106.1 of Title 19 NYCRR.

Statutory authority: Executive Law, section 160-d(1)(d)

Subject: Uniform Standards of Professional Appraisal Practice.

Purpose: To adopt the 2012-2013 edition of the Uniform Standards of Professional Appraisal Practice.

Text or summary was published in the October 12, 2011 issue of the Register, I.D. No. DOS-41-11-00001-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Whitney Clark, NYS Department of State, Division of Licensing Services, Alfred E Smith Office Building, 80 South Swan Street, Albany, NY 12231, (518) 473-2728, email: whitney.clark@dos.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Workers' Compensation Board

EMERGENCY RULE MAKING

Pharmacy and Durable Medical Equipment Fee Schedules and Requirements for Designated Pharmacies

I.D. No. WCB-52-11-00001-E

Filing No. 1321

Filing Date: 2011-12-07

Effective Date: 2011-12-08

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

Action taken: Addition of Parts 440 and 442 to Title 12 NYCRR.

Statutory authority: Workers' Compensation Law, sections 117, 13 and 13-o

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: This rule provides pharmacy and durable medical equipment fee schedules, the process for payment of pharmacy bills, and rules for the use of a designated pharmacy or pharmacies. Many times claimants must pay for prescription drugs and medicines themselves. It is unduly burdensome for claimants to pay out-of-pocket for prescription medications as it reduces the amount of benefits available to them to pay for necessities such as food and shelter. Claimants also have to pay out-of-pocket many times for durable medical equipment. Adoption of this rule on an emergency basis, thereby setting pharmacy and durable medical equipment fee schedules will help to alleviate this burden to claimants, effectively maximizing the benefits available to them. Benefits will be maximized as the claimant will only have to pay the fee schedule amount and there reimbursement from the carrier will not be delayed. Further, by setting these fee schedules, pharmacies and other suppliers of durable medical equipment will be more inclined to dispense the prescription drugs or equipment without requiring claimants to pay up front, rather they will bill the carrier. Adoption of this rule further advances pharmacies directly billing by setting forth the requirements for the carrier to designate a pharmacy or network of pharmacies. Once a carrier makes such a designation, when a claimant uses a designated pharmacy he cannot be asked to pay out-of-pocket for causally related prescription medicines. This rule sets forth the payment process for pharmacy bills which along with the set price should eliminate disputes over payment and provide for faster payment to pharmacies. Finally, this rule allows claimants to fill prescriptions by the internet or mail order thus aiding claimants with mobility problems and reducing transportation costs necessary to drive to a pharmacy to fill prescriptions. Accordingly, emergency adoption of this rule is necessary.

Subject: Pharmacy and durable medical equipment fee schedules and requirements for designated pharmacies.

Purpose: To adopt pharmacy and durable medical equipment fee schedules, payment process and requirements for use of designated pharmacies.

Substance of emergency rule: Chapter 6 of the Laws of 2007 added Section 13-o to the Workers' Compensation Law ("WCL") mandating the Chair to adopt a pharmaceutical fee schedule. WCL Section 13(a) mandates that the Chair shall establish a schedule for charges and fees for medical care and treatment. Part of the treatment listed under Section 13(a) includes medical supplies and devices that are classified as durable medical equipment. The proposed rule adopts a pharmaceutical fee schedule and durable medical equipment fee schedule to comply with the mandates. This rule adds a new Part 440 which sets forth the pharmacy fee schedule and procedures and rules for utilization of the pharmacy fee schedule and a new Part 442 which sets forth the durable medical equipment fee schedule.

Section 440.1 sets forth that the pharmacy fee schedule is applicable to prescription drugs or medicines dispensed on or after the most recent effective date of § 440.5 and the reimbursement for drugs dispensed before that is the fee schedule in place on the date dispensed.

Section 440.2 provides the definitions for average wholesale price, brand name drugs, controlled substances, generic drugs, independent pharmacy, pharmacy chain, remote pharmacy, rural area and third party payor.

Section 440.3 provides that a carrier or self-insured employer may designate a pharmacy or pharmacy network which an injured worker must

use to fill prescriptions for work related injuries. This section sets forth the requirements applicable to pharmacies that are designated as part of a pharmacy network at which an injured worker must fill prescriptions. This section also sets forth the procedures applicable in circumstances under which an injured worker is not required to use a designated pharmacy or pharmacy network.

Section 440.4 sets forth the requirements for notification to the injured worker that the carrier or self-insured employer has designated a pharmacy or pharmacy network that the injured worker must use to fill prescriptions. This section provides the information that must be provided in the notice to the injured worker including time frames for notice and method of delivery as well as notifications of changes in a pharmacy network.

Section 440.5 sets forth the fee schedule for prescription drugs. The fee schedule in uncontroverted cases is average wholesale price minus twelve percent for brand name drugs and average wholesale price minus twenty percent for generic drugs plus a dispensing fee of five dollars for generic drugs and four dollars for brand name drugs, and in controverted cases is twenty-five percent above the fee schedule for uncontroverted claims plus a dispensing fee of seven dollars and fifty cents for generic drugs and six dollars for brand-name drugs. This section also addresses the fee when a drug is repackaged.

Section 440.6 provides that generic drugs shall be prescribed except as otherwise permitted by law.

Section 440.7 sets forth a transition period for injured workers to transfer prescriptions to a designated pharmacy or pharmacy network. Prescriptions for controlled substances must be transferred when all refills for the prescription are exhausted or after ninety days following notification of a designated pharmacy. Non-controlled substances must be transferred to a designated pharmacy when all refills are exhausted or after 60 days following notification.

Section 440.8 sets forth the procedure for payment of prescription bills or reimbursement. A carrier or self-insured employer is required to pay any undisputed bill or portion of a bill and notify the injured worker by certified mail within 45 days of receipt of the bill of the reasons why the bill or portion of the bill is not being paid, or request documentation to determine the self-insured employer's or carrier's liability for the bill. If objection to a bill or portion of a bill is not received within 45 days, then the self-insured employer or carrier is deemed to have waived any objection to payment of the bill and must pay the bill. This section also provides that a pharmacy shall not charge an injured worker or third party more than the pharmacy fee schedule when the injured worker pays for prescriptions out-of-pocket, and the worker or third party shall be reimbursed at that rate.

Section 440.9 provides that if an injured worker's primary language is other than English, that notices required under this part must be in the injured worker's primary language.

Section 440.10 provides penalties for failing to comply with this Part and that the Chair will enforce the rule by exercising his authority pursuant to Workers' Compensation Law § 111 to request documents.

Part 442 sets forth the fee schedule for durable medical equipment.

Section 442.1 sets forth that the fee schedule is applicable to durable medical goods and medical and surgical supplies dispensed on or after July 11, 2007.

Section 442.2 sets forth the fee schedule for durable medical equipment as indexed to the New York State Medicaid fee schedule, except the payment for bone growth stimulators shall be made in one payment. This section also provides for the rate of reimbursement when Medicaid has not established a fee payable for a specific item and for orthopedic footwear. This section also provides for adjustments to the fee schedule by the Chair as deemed appropriate in circumstances where the reimbursement amount is grossly inadequate to meet a pharmacies or providers costs and clarifies that hearing aids are not durable medical equipment for purposes of this rule.

Appendix A provides the form for notifying injured workers that the claim has been contested and that the carrier is not required to reimburse for medications while the claim is being contested.

Appendix B provides the form for notification of injured workers that the self-insured employer or carrier has designated a pharmacy that must be used to fill prescriptions.

This notice is intended to serve only as an emergency adoption, to be valid for 90 days or less. This rule expires March 5, 2012.

Text of rule and any required statements and analyses may be obtained from: Heather MacMaster, Esq., New York State Workers' Compensation Board, 20 Park Street, Office of General Counsel, Albany, New York 12207, (518) 486-9564, email: regulations@wcb.state.ny.us

Summary of Regulatory Impact Statement

Section 1 provides the statutory authority for the Chair to adopt a pharmacy fee schedule pursuant to Workers' Compensation Law Section (WCL) 13-o as added to the WCL by Chapter 6 of the Laws of 2007 which

requires the Chair to adopt a pharmaceutical fee schedule. Chapter 6 also amended WCL Section 13(a) to mandate that the Chair establish a schedule for charges and fees for medical care and treatment. Such medical care and treatment includes supplies and devices that are classified as durable medical equipment (hereinafter referred to as DME).

Section 2 sets forth the legislative objectives of the proposed regulations which provide the fee schedules to govern the cost of prescription medicines and DME. This section provides a summary of the overall purpose of the proposed regulation to reduce costs of workers' compensation and the scope of the regulation with regard to process and guidance to implement the rule.

Section 3 explains the needs and benefits of the proposed regulation. This section provides the explanation of the requirement of the Chair to adopt a pharmacy fee schedule as mandated by Chapter 6 of the Laws of 2007. The legislation authorizes carriers and self-insured employers to voluntarily decide to designate a pharmacy or pharmacy network and require claimants to obtain their prescription medicines from the designated pharmacy or network. This section explains how prescriptions were filled prior to the enactment of the legislation and the mechanisms by which prescriptions were reimbursed by carriers and self-insured employers. This section also provides the basis for savings under the proposed regulation. The cost savings realized by using the pharmacy fee schedule will be approximately 12 percent for brand name drugs and 20 percent for generic drugs from the average wholesale price. This section explains the issues with using the Medicaid fee schedule. The substantive requirements are set forth that carriers must follow to notify a claimant of a designated pharmacy or network. This includes the information that must be included in the notification as well as the time frames within which notice must be provided. This section also describes how carriers and self-insured employers will benefit from a set reimbursement fee as provided by the proposed regulation. This section provides a description of the benefits to the Board by explaining how the proposed regulation will reduce the number of hearings previously necessary to determine proper reimbursement of prescription medications by using a set fee schedule.

Section 4 provides an explanation of the costs associated with the proposed regulation. It describes how carriers are liable for the cost of medication if they do not respond to a bill within 45 days as required by statute. This section describes how carriers and self-insured employers which decide to require the use of a designated network will incur costs for sending the required notices, but also describes how the costs can be offset to a certain degree by sending the notices listed in the Appendices to the regulation with other forms. Pharmacies will have costs associated with the proposed regulation due to a lower reimbursement amount, but the costs are offset by the reduction of administrative costs associated with seeking reimbursement from carriers and self-insured employers. Pharmacies will be required to post notice that they are included in a designated network and a listing of carriers that utilize the pharmacy in the network. This section describes how the rule benefits carriers and self-insured employers by allowing them to contract with a pharmacy or network to provide drugs thus allowing them to negotiate for the lowest cost of drugs.

Section 5 describes how the rule will affect local governments. Since a municipality of governmental agency is required to comply with the rules for prescription drug reimbursement the savings afforded to carriers and self-insured employers will be substantially the same for local governments. If a local government decides to mandate the use of a designated network it will incur some costs from providing the required notice.

Section 6 describes the paperwork requirements that must be met by carriers, employers and pharmacies. Carriers will be required to provide notice to employers of a designated pharmacy or network, and employers in turn will provide such notice to employees so that employees will know to use a designated pharmacy or network for prescription drugs. Pharmacies will be required to post notice that they are part of a designated network and a listing of carriers that utilize the pharmacy within the network. This section also specifies the requirement of a carrier or self-insured employer to respond to a bill within 45 days of receipt. If a response is not given within the time frame, the carrier or self-insured employer is deemed to have waived any objection and must pay the bill. This section sets forth the requirement of carriers to certify to the Board that designated pharmacies within a network meet compliance requirements for inclusion in the network. This section sets forth that employers must post notification of a designated pharmacy or network in the workplace and the procedures for utilizing the designated pharmacy or network. This section also sets forth how the Chair will enforce compliance with the rule by seeking documents pursuant to his authority under WCL § 111 and impose penalties for non-compliance.

Section 7 states that there is no duplication of rules or regulations.

Section 8 describes the alternatives explored by the Board in creating the proposed regulation. This section lists the entities contacted in regard

to soliciting comments on the regulation and the entities that were included in the development process. The Board studied fee schedules from other states and the applicability of reimbursement rates to New York State. Alternatives included the Medicaid fee schedule, average wholesale price minus 15% for brand and generic drugs, the Medicare fee schedule and straight average wholesale price.

Section 9 states that there are no applicable Federal Standards to the proposed regulation.

Section 10 provides the compliance schedule for the proposed regulation. It states that compliance is mandatory and that the proposed regulation takes effect upon adoption.

Regulatory Flexibility Analysis

1. Effect of rule:

Approximately 2511 political subdivisions currently participate as municipal employers in self-insured programs for workers' compensation coverage in New York State. As part of the overall rule, these self-insured local governments will be required to file objections to prescription drug bills if they object to any such bills. This process is required by WCL § 13(i)(1) - (2). This rule affects members of self-insured trusts, some of which are small businesses. Typically a self-insured trust utilizes a third party administrator or group administrator to process workers' compensation claims. A third party administrator or group administrator is an entity which must comply with the new rule. These entities will be subject to the new rule in the same manner as any other carrier or employer subject to the rule. Under the rule, objections to a prescription bill must be filed within 45 days of the date of receipt of the bill or the objection is deemed waived and the carrier, third party administrator, or self-insured employer is responsible for payment of the bill. Additionally, affected entities must provide notification to the claimant if they choose to designate a pharmacy network, as well as the procedures necessary to fill prescriptions at the network pharmacy. If a network pharmacy is designated, a certification must be filed with the Board on an annual basis to certify that all pharmacies in a network comply with the new rule. The new rule will provide savings to small businesses and local governments by reducing the cost of prescription drugs by utilization of a pharmacy fee schedule instead of retail pricing. Litigation costs associated with reimbursement rates for prescription drugs will be substantially reduced or eliminated because the rule sets the price for reimbursement. Additional savings will be realized by utilization of a network pharmacy and a negotiated fee schedule for network prices for prescription drugs.

2. Compliance requirements:

Self-insured municipal employers and self-insured non-municipal employers are required by statute to file objections to prescription drug bills within a forty five day time period if they object to bills; otherwise they will be liable to pay the bills if the objection is not timely filed. If the carrier or self-insured employer decides to require the use of a pharmacy network, notice to the injured worker must be provided outlining that a network pharmacy has been designated and the procedures necessary to fill prescriptions at the network pharmacy. Certification by carriers and self-insured employers must be filed on an annual basis with the Board that all the pharmacies in a network are in compliance with the new rule. Failure to comply with the provisions of the rule will result in requests for information pursuant to the Chair's existing statutory authority and the imposition of penalties.

3. Professional services:

It is believed that no professional services will be needed to comply with this rule.

4. Compliance costs:

This proposal will impose minimal compliance costs on small business or local governments which will be more than offset by the savings afforded by the fee schedule. There are filing and notification requirements that must be met by small business and local governments as well as any other entity that chooses to utilize a pharmacy network. Notices are required to be posted in the workplace informing workers of a designated network pharmacy. Additionally, a certification must be filed with the Board on an annual basis certifying that all pharmacies within a network are in compliance with the rule.

5. Economic and technological feasibility:

There are no additional implementation or technology costs to comply with this rule. The small businesses and local governments are already familiar with average wholesale price and regularly used that information prior to the adoption of the Medicaid fee schedule. Further, some of the reimbursement levels on the Medicaid fee schedule were determined by using the Medicaid discounts off of the average wholesale price. The Red Book is the source for average whole sale prices and it can be obtained for less than \$100.00. Since the Board stores its claim files electronically, it has provided access to case files through its eCase program to parties of interest in workers' compensation claims. Most insurance carriers, self-insured employers and third party administrators have computers and internet access in order to take advantage of the ability to review claim files from their offices.

6. Minimizing adverse impact:

This proposed rule is designed to minimize adverse impacts to all insurance carriers, employers, self-insured employers and claimants. The rule provides a process for reimbursement of prescription drugs as mandated by WCL section 13(i). Further, the notice requirements are to ensure a claimant uses a network pharmacy to maximize savings for the employer as any savings for the carrier can be passed on to the employer. The costs for compliance are minimal and are offset by the savings from the fee schedule. The rule sets the fee schedule as average wholesale price (AWP) minus twelve percent for brand name drugs and AWP minus twenty percent for generic drugs. As of July 1, 2008, the reimbursement for brand name drugs on the Medicaid Fee Schedule was reduced from AWP minus fourteen percent to AWP minus sixteen and a quarter percent. Even before the reduction in reimbursement some pharmacies, especially small ones, were refusing to fill brand name prescriptions because the reimbursement did not cover the cost to the pharmacy to purchase the medication. In addition the Medicaid fee schedule did not cover all drugs, include a number that are commonly prescribed for workers' compensation claims. This presented a problem because WCL § 13-o provides that only drugs on the fee schedule can be reimbursed unless approved by the Chair. The fee schedule adopted by this regulation eliminates this problem. Finally, some pharmacy benefit managers were no longer doing business in New York because the reimbursement level was so low they could not cover costs. Pharmacy benefit managers help to create networks, assist claimants in obtaining first fills without out of pocket costs and provide utilization review. Amending the fee schedule will ensure pharmacy benefit managers can stay in New York and help to ensure access for claimants without out of pocket cost.

7. Small business and local government participation:

The Assembly and Senate as well as the Business Council of New York State and the AFL-CIO provided input on the proposed rule.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas:

This rule applies to all carriers, employers, self-insured employers, third party administrators and pharmacies in rural areas. This includes all municipalities in rural areas.

2. Reporting, recordkeeping and other compliance requirements:

Regulated parties in all areas of the state, including rural areas, will be required to file objections to prescription drug bills within a forty five day time period or will be liable for payment of a bill. If regulated parties fail to comply with the provisions of Part 440 penalties will be imposed and the Chair will request documentation from them to enforce the provision regarding the pharmacy fee schedule. The new requirement is solely to expedite processing of prescription drug bills or durable medical bills under the existing obligation under Section 13 of the WCL. Notice to the injured worker must be provided outlining that a network pharmacy has been designated and the procedures necessary to fill prescriptions at the network pharmacy. Carriers and self-insured employers must file a certification on an annual basis with the Board that all the pharmacies in a network are in compliance with the new rule.

3. Costs:

This proposal will impose minimal compliance costs on carriers and employers across the State, including rural areas, which will be more than offset by the savings afforded by the fee schedule. There are filing and notification requirements that must be met by all entities subject to this rule. Notices are required to be posted and distributed in the workplace informing workers of a designated network pharmacy and objections to prescription drug bills must be filed within 45 days or the objection to the bill is deemed waived and must be paid without regard to liability for the bill. Additionally, a certification must be filed with the Board on an annual basis certifying that all pharmacies within a network are in compliance with the rule. The rule provides a reimbursement standard for an existing administrative process.

4. Minimizing adverse impact:

This proposed rule is designed to minimize adverse impact for small businesses and local government from imposition of new fee schedules and payment procedures. This rule provides a benefit to small businesses and local governments by providing a uniform pricing standard, thereby providing cost savings reducing disputes involving the proper amount of reimbursement or payment for prescription drugs or durable medical equipment. The rule mitigates the negative impact from the reduction in the Medicaid fee schedule effective July 1, 2008, by setting the fee schedule at Average Wholesale Price (AWP) minus twelve percent for brand name prescription drugs and AWP minus twenty percent for generic prescription drugs. In addition, the Medicaid fee schedule did not cover many drugs that are commonly prescribed for workers' compensation claimants. This fee schedule covers all drugs and addresses the potential issue of repackagers who might try to increase reimbursements.

5. Rural area participation:

Comments were received from the Assembly and the Senate, as well as

the Business Council of New York State and the AFL-CIO regarding the impact on rural areas.

Job Impact Statement

The proposed amendment will not have an adverse impact on jobs. This amendment is intended to provide a standard for reimbursement of pharmacy and durable medical equipment bills.