

# 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.

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## Department of Financial Services

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### EMERGENCY RULE MAKING

#### Confidentiality Protocols for Victims of Domestic Violence and Endangered Individuals

**I.D. No.** DFS-41-13-00008-E

**Filing No.** 147

**Filing Date:** 2014-02-14

**Effective Date:** 2014-02-14

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

**Action taken:** Addition of Part 244 (Regulation 168) to Title 11 NYCRR.

**Statutory authority:** Financial Services Law, sections 202 and 302; and Insurance Law, sections 301 and 2612

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

**Specific reasons underlying the finding of necessity:** This regulation governs confidentiality protocols for domestic violence victims and endangered individuals. Insurance Law § 2612 states that if any person covered by an insurance policy issued to another person who is the policyholder or if any person covered under a group policy delivers to the insurer that issued the policy, a valid order of protection against the policyholder or other person, then the insurer is prohibited for the duration of the order from disclosing to the policyholder or other person the address and telephone number of the insured, or of any person or entity providing covered services to the insured.

In addition, on October 25, 2012, Governor Andrew M. Cuomo signed into law Chapter 491 of the Laws of 2012, effective January 1, 2013, Part E of which amends Insurance Law § 2612 to require a health insurer to ac-

commodate a reasonable request made by a person covered by an insurance policy or contract issued by the health insurer to receive communications of claim related information from the health insurer by alternative means or at alternative locations if the person clearly states that disclosure of all or part of the information could endanger the person. Except with the express consent of the person making the request, the amendment prohibits a health insurer from disclosing to the policyholder: (1) the address, telephone number, or any other personally identifying information of the person who made the request or child for whose benefit a request was made; (2) the nature of the health care services provided; or (3) the name or address of the provider of the covered services.

Insurance Law § 2612 requires the Superintendent, in consultation with the Commissioner of Health, Office of Children and Family Services, and Office for the Prevention of Domestic Violence, to promulgate rules to guide and enable insurers to guard against the disclosure of the confidential information protected by § 2612. Section 2612 provides important protections to persons who may be subject to domestic violence.

For the reasons stated above, emergency action is necessary for the general welfare.

**Subject:** Confidentiality Protocols for Victims of Domestic Violence and Endangered Individuals.

**Purpose:** To establish requirements for insurers to effectively respond to certain requests to keep records and information confidential.

**Text of emergency rule:** Section 244.0 Preamble.

*Individuals experiencing actual or threatened violence frequently establish new addresses and telephone numbers to protect their health and safety. Insurance Law section 2612 requires the Superintendent of Financial Services, in consultation with the Commissioner of Health, Office of Children and Family Services, and Office for the Prevention of Domestic Violence, to promulgate rules to guide and enable insurers to guard against the disclosure of information protected by Insurance Law section 2612. This Part establishes requirements with which insurers shall comply to enable them to effectively respond to requests to keep records and information confidential in conformance with Insurance Law section 2612.*

*Section 244.1 Applicability.*

*(a) This Part shall apply to a policy issued pursuant to the Insurance Law.*

*(b) With respect to an insurer authorized to write kinds of insurance in addition to accident and health insurance or salary protection insurance, any section of this Part that establishes rules with regard to a requestor or covered individual shall apply only with respect to a policy of accident and health insurance or a policy of salary protection insurance.*

*Section 244.2 Definitions.*

*As used in this Part:*

*(a) Accident and health insurance shall have the meaning set forth in Insurance Law section 1113(a)(3) and with regard to a fraternal benefit society, also shall have the meaning set forth in Insurance Law section 4501(i)-(k), (m), (o), and (p).*

*(b) Address means a street address, mailing address, or e-mail address.*

*(c) Claim related information shall have the meaning set forth in Insurance Law section 2612(h)(1)(A).*

*(d) Covered individual means an individual covered under a policy issued by a health insurer who could be endangered by the disclosure of all or part of claim related information by the health insurer.*

*(e) Fraternal benefit society shall have the meaning set forth in Insurance Law section 4501(a).*

*(f) Health insurer shall have the meaning set forth in Insurance Law section 2612(h)(1)(B).*

*(g) Insured means an individual who is covered under an individual or a group policy.*

*(h) Insurer shall have the meaning set forth in Insurance Law section 2612(c)(2) and shall include a fraternal benefit society.*

*(i) Person means an individual or legal entity, including a partnership, limited liability company, association, trust, or corporation.*

(j) Policy means a policy, contract, or certificate of insurance, an annuity contract, a child health insurance plan issued pursuant to Title 1-A of Public Health Law Article 25, medical assistance or health care services provided pursuant to Title 11 or 11-D of Social Services Law Article 5, or any certificate issued under any of the foregoing.

(k) Policyholder means a person to whom a policy has been issued.

(l) Reasonable request means a request that contains a statement that disclosure of all or part of the claim related information to which the request pertains could endanger an individual, and the specification of an alternative address, telephone number, or other method of contact.

(m) Requestor means a covered individual, or the individual's legal representative, or with regard to a covered individual who is a child, the child's parent or guardian, who makes a reasonable request to the health insurer.

(n) Salary protection insurance shall have the meaning set forth in Insurance Law section 1113(a)(31).

(o) Victim of domestic violence or victim shall have the meaning set forth in Social Services Law section 459-a(1).

#### Section 244.3 Confidentiality protocol.

(a) An insurer shall develop and implement a confidentiality protocol whereby, except with the express consent of the individual who delivers to the insurer a valid order of protection, the insurer shall keep confidential and shall not disclose the address and telephone number of the victim of domestic violence, or any child residing with the victim, and the name, address, and telephone number of a person providing covered services to the victim, to a policyholder or another insured covered under the policy against whom the victim has a valid order of protection, if the victim, the victim's legal representative, or if the victim is a child, the child's parent or guardian, delivers to the insurer at its home office a valid order of protection pursuant to Insurance Law section 2612(f) and (g).

(b) In addition to the requirements of subdivision (a) of this section, a health insurer shall develop and implement a confidentiality protocol whereby the health insurer shall accommodate a reasonable request made by a requestor for a covered individual to receive communications of claim related information from the health insurer by alternative means or at alternative locations. Except with the express consent of the requestor, a health insurer shall not disclose to the policyholder or another insured covered under the policy:

(1) the address, telephone number, or any other personally identifying information of the covered individual or any child residing with the covered individual;

(2) the nature of the health care services provided to the covered individual;

(3) the name, address, and telephone number of the provider of the covered health care services; or

(4) any other information from which there is a reasonable basis to believe the foregoing information could be obtained.

(c) The insurer's confidentiality protocol shall include written procedures to be followed by its employees, agents, representatives, or other persons with whom the insurer contracts and who may have access to the information sought to be kept confidential. The written procedures shall include:

(1) with respect to a health insurer, the procedure by which a requestor may make a reasonable request, provided that the procedure shall not require a justification as part of the reasonable request;

(2) the procedure by which a victim of domestic violence or a covered individual may provide an alternative address, telephone number, or other method of contact;

(3) the procedure for limiting access to personally identifying information, such as the name, address, telephone number, and social security number of a victim or covered individual and any other information from which there is a reasonable basis to believe the foregoing information could be obtained;

(4) the procedure for limiting or removing personal identifiers before information is used or disclosed, where possible;

(5) a system of internal control procedures, which the insurer shall review at least annually, to ensure the confidentiality of:

(i) addresses, telephone numbers, or other methods of contact;

(ii) the fact that a requestor made a reasonable request or that an order of protection was delivered to the insurer, and any information contained therein; and

(iii) any other information from which there is a reasonable basis to believe the information specified in subparagraphs (i) and (ii) could be obtained; and

(6) with respect to a health insurer, the procedure by which a requestor may revoke a reasonable request, provided, however, that the health insurer may require the requestor to submit a sworn statement revoking the request.

(d)(1) An insurer shall notify its employees, agents, representatives, and other persons with whom the insurer contracts who have access to the

information sought to be kept confidential, that the insurer's protocol is to be followed for the specified victim of domestic violence or covered individual, within three business days of:

(i) receipt of a valid order of protection and an alternative address, telephone number, or other method of contact; or

(ii) receipt of a reasonable request, with regard to a health insurer.

(2) Upon receipt of a valid order of protection or a reasonable request, an insurer shall inform the individual who delivered the order of protection or the requestor that the insurer has up to three business days to implement paragraph (1) of this subdivision.

(e) A health insurer may require a requestor to make a reasonable request in writing pursuant to Insurance Law section 2612(h)(3). However, a health insurer may not require a requestor to provide a justification for the reasonable request.

(f)(1) Prior to releasing any information prohibited to be disclosed pursuant to subdivisions (a) and (b) of this section pursuant to a warrant, subpoena, or court order involving the policyholder or another insured covered under the policy, an insurer shall notify the individual who delivered the order of protection or the requestor, as soon as reasonably practicable, that it intends to release information and specify what type of information it intends to release, unless prohibited by the warrant, subpoena, or court order.

(2) Upon release of information pursuant to a warrant, subpoena, or court order, an insurer shall advise the person to whom the insurer is releasing the information that the information is confidential and that the person should continue to maintain the confidentiality of the information to the extent possible.

(g) An insurer shall comply with Parts 420 and 421 of this Title (Insurance Regulations 169 and 173) and where applicable, the federal Health Insurance Portability and Accountability Act of 1996, as amended, with respect to any information submitted pursuant to Insurance Law section 2612 or this Part.

(h) An agent, representative, or designee of an insurer, a corporation organized pursuant to Insurance Law Article 43, a health maintenance organization certified pursuant to Public Health Law Article 44, or a provider issued a special certificate of authority pursuant to Public Health Law section 4403-a, who is regulated pursuant to the Insurance Law, need not develop its own confidentiality protocol pursuant to this section if the agent, representative, or designee follows the protocol of the insurer, corporation, health maintenance organization, or provider.

#### Section 244.4 Notice.

(a) An insurer shall post conspicuously on its website and, with regard to a health insurer, also annually provide all its participating health service providers with:

(1) a description of Insurance Law section 2612;

(2) the information required by section 244.3(c)(1), (2), and (6); and

(3) the phone number for the New York State Domestic and Sexual Violence Hotline.

(b) An insurer shall post conspicuously on its website the information set forth in paragraphs (1) and (3) of subdivision (a) of this section in a format suitable for printing and posting. A health insurer shall recommend to its participating health service providers that the providers print and post the information in their offices.

(c) This section shall not apply to an agent, representative, or designee of an insurer, a corporation organized pursuant to Insurance Law Article 43, a health maintenance organization certified pursuant to Public Health Law Article 44, or a provider issued a special certificate of authority pursuant to Public Health Law section 4403-a, who is regulated pursuant to the Insurance Law, if the agent, representative, or designee follows the protocol of the insurer, corporation, health maintenance organization, or provider.

**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. DFS-41-13-00008-EP, Issue of October 9, 2013. The emergency rule will expire April 14, 2014.

**Text of rule and any required statements and analyses may be obtained from:** Joana Lucashuk, New York State Department of Financial Services, One State Street, New York, NY 10004, (212) 480-2125, email: joana.lucashuk@dfs.ny.gov

#### Regulatory Impact Statement

1. Statutory authority: Financial Services Law §§ 202 and 302 and Insurance Law §§ 301 and 2612.

Financial Services Law §§ 202 and 302 and Insurance Law § 301 authorize the Superintendent of Financial Services (the "Superintendent") to prescribe regulations interpreting the provisions of the Insurance Law and to effectuate any power granted to the Superintendent under the Insurance Law.

Insurance Law § 2612 requires the Superintendent to promulgate rules

to guide and enable insurers (as § 2612 defines that term, which includes health maintenance organizations as well as agents, representatives, and designees of the insurers that are regulated under the Insurance Law) to guard against the disclosure of confidential information protected by Insurance Law § 2612.

2. Legislative objectives: Insurance Law § 2612, with respect to every insurer regulated under the Insurance Law, provides in relevant part that if any person covered by an insurance policy delivers to the insurer a valid order of protection against the policyholder or other covered person, then the insurer cannot, for the duration of the order, disclose to the policyholder or other person the address and telephone number of the insured, or of any person or entity providing covered services to the insured. Section 2612 also requires a health insurer, as defined in that section, to accommodate a reasonable request made by a person covered by an insurance policy or contract to receive communications of claim-related information by alternative means or at alternative locations if the person clearly states that disclosure of the information could endanger the person. This section further prohibits a health insurer from disclosing certain information to the policyholder.

The Legislature enacted Insurance Law § 2612, and amendments thereto, to protect domestic violence victims and to ensure that an abuser has one less record that the abuser may use to track down the victim. This rule is consistent with the public policy objectives that the Legislature sought to advance by enacting § 2612, because the rule helps to protect domestic violence victims by guiding and enabling insurers to guard against the disclosure of the confidential information protected by § 2612.

3. Needs and benefits: Insurance Law § 2612 requires the Superintendent, in consultation with the Commissioner of Health, Office of Children and Family Services, and Office for the Prevention of Domestic Violence, to promulgate rules to guide and enable insurers to guard against the disclosure of the confidential information protected by Insurance Law § 2612. Therefore, after consultation with the Commissioner of Health, the Office of Children and Family Services, and the Office for the Prevention of Domestic Violence, the Superintendent drafted this rule to guide and enable insurers to guard against disclosure.

4. Costs: The rule may impose compliance costs on insurers because it requires insurers to develop confidentiality protocols and provide certain notices. However, such costs are difficult to estimate and will vary depending upon a number of factors, including the size of the insurer. In fact, insurers already should be complying with the existing requirements of the statute. Moreover, the rule is designed to provide flexibility to insurers and does not prescribe the way in which an insurer must provide the notices, but rather leaves the method up to each insurer. In addition, an agent, representative, or designee of an insurer that is regulated pursuant to the Insurance Law need not establish its own protocol or give certain notices, provided that it follows the protocol of the insurer. In any event, the requirement that insurers may not disclose the information protected by Insurance Law § 2612 is mandated by the statute itself, not the rule.

The Department does not anticipate significant additional costs to the Department to implement the rule. The Department will monitor compliance with the rule as part of its market conduct examinations of insurers and consumer complaint handling procedures.

The regulation does not impose compliance costs on state or local governments because it is not applicable to them.

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

6. Paperwork: The rule requires an insurer to notify its employees, agents, representatives, or other persons with whom the insurer contracts or who have gained access to the information from the insurer, with respect to the solicitation, negotiation, or sale of insurance or the adjustment or administration of insurance claims, that the insurer's confidentiality protocol is to be followed for the specified victim of domestic violence or covered individual, within three business days of receipt of a valid order of protection and an alternative address, telephone number, or other method of contact, or receipt of a reasonable request, with regard to a health insurer.

The rule also requires a health insurer to annually provide to all of its participating health service providers a description of Insurance Law § 2612, certain information contained within the insurer's confidentiality protocol, and the phone number of the New York State Domestic and Sexual Violence Hotline.

7. Duplication: The rule does not duplicate, overlap, or conflict with any state rules or other legal requirements. The rule may overlap with the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, and may impose additional requirements that are not set forth in HIPAA. However, the rule does not conflict with HIPAA.

8. Alternatives: Originally, the rule required an insurer's confidentiality protocol to have written procedures to be followed by its employees, agents, representatives, or any other persons with whom the insurer

contracted or who had gained access to the information from the insurer, with respect to the solicitation, negotiation, or sale of insurance or the adjustment or administration of insurance claims. The rule also required an insurer to notify the foregoing persons that the insurer's protocol was to be followed for the specified domestic violence victim or covered individual within three business days of receipt of a valid order of protection and alternative contact information, or receipt of a reasonable request, with regard to a health insurer.

After receiving comments from trade associations representing life and property/casualty insurers, the Department, recognizing that the rule could be construed in an overly broad way, clarified the rule to require that the written procedures in the insurer's confidentiality protocol be followed by its employees, agents, representatives, and persons with whom the insurer contracts where such employees, agents, representatives, or persons may have access to the information sought to be kept confidential. The Department also amended the rule to require an insurer to notify its employees, agents, representatives, and persons with whom the insurer contracts where such employees, agents, representatives, or persons have access to the information sought to be kept confidential, that the insurer's protocol is to be followed for the specified domestic violence victim or covered individual within three business days of receipt of a valid order of protection and alternative contact information, or receipt of a reasonable request, with regard to a health insurer.

The rule also originally stated that prior to releasing any information pursuant to a warrant, subpoena, or court order, an insurer must notify the individual who delivered the order of protection or the requestor, as soon as reasonably practicable, that it intends to release information and specify the type of information it intends to release, unless prohibited by the warrant, subpoena, or court order. However, after receiving an inquiry from an attorney that represents health insurers, the Department amended this language to make clear that the information to which the language is referring is limited to the information barred from disclosure by § 244.3(a) and (b) of the rule, and that the warrant, subpoena, or court order must involve the policyholder or another insured covered under the policy.

In addition, the Department had included language in the rule that prohibited an insurer or any person subject to the Insurance Law from engaging in any practice that would prevent or hamper the orderly working of the rule in accomplishing its intended purpose of protecting domestic violence victims and covered individuals. A trade organization questioned how a person would prevent or hamper the orderly working of the rule. After further discussion, the Department deleted the foregoing language.

Finally, a trade organization stated that it was not always clear which provisions applied only to health insurers. The Department revised the rule to make clearer when it applies to all insurers and when it applies just to health insurers.

9. Federal standards: HIPAA sets forth rules for restricting the use and disclosure of certain health information and permits an individual to make a request to a health plan to receive communications of protected health information from the health plan by alternative means or at alternative locations if the individual clearly states that the disclosure of all or part of the information could endanger the individual. Insurance Law § 2612, as amended by Chapter 491, and this rule, are consistent with HIPAA. However, § 2612 and the rule may impose additional requirements that are not set forth in HIPAA. For example, the rule sets forth required elements of a confidentiality protocol and requires insurers to provide notice of their confidentiality protocols and of Insurance Law § 2612 by posting certain information on their websites.

10. Compliance schedule: The existing statute already requires an insurer to protect certain information when a person provides the insurer with an order of protection. The new requirements of Insurance Law § 2612 took effect on January 1, 2013. This regulation has been in effect on an emergency basis since June 27, 2013. Insurers had to post certain information on their websites by July 1, 2013.

#### **Regulatory Flexibility Analysis**

1. Effect of rule: The rule will not affect any local governments. It will affect regulated insurers, most of which do not come within the definition of "small business" as set forth in State Administrative Procedure Act § 102(8), because they are not independently owned and operated and employ less than one hundred individuals. The rule also would affect insurance producers and independent insurance adjusters, the vast majority of which are small businesses, because they are independently owned and operated and employ one hundred or less individuals. There are over 200,000 licensed resident and non-resident insurance producers and over 15,000 licensed resident and non-resident independent insurance adjusters in New York that the rule will affect. The Department does not have a record of the exact number of small businesses included in that group. The Department has designed the regulation to place the least burden possible on insurance producers and independent insurance adjusters, as discussed below.

2. Compliance requirements: Insurance Law § 2612(c)(2) and (h)(1)(A) define “insurer” and “health insurer,” respectively, to include an agent, representative, or designee of an insurer, a corporation organized pursuant to Insurance Law Article 43, a health maintenance organization (“HMO”), a municipal cooperative health benefit plan, or a provider issued a special certificate of authority pursuant to Public Health Law § 4403-a, who is regulated pursuant to the Insurance Law. The rule requires insurers (including health insurers) to develop and implement confidentiality protocols that include written procedures that their employees, agents, representatives, or any other persons with whom the insurers contract or who have gained access to the information from the insurers, with regard to the solicitation, negotiation, or sale of insurance or the adjustment or administration of insurance claims, must follow. The rule also requires insurers to post certain information on their websites. Since, an agent, representative, or designee who is regulated pursuant to the Insurance Law is included in the definitions of “insurer” and “health insurer,” these requirements apply to insurance agents and independent insurance adjusters. In certain cases, insurance brokers may act on behalf of insurers, such as when they administer insurance programs for the insurers, and thus the rule would apply to brokers as well. Furthermore, the rule prohibits any person subject to the Insurance Law from engaging in any practice that would prevent or hamper the orderly working of the rule in accomplishing its intended purpose of protecting victims of domestic violence and covered individuals.

However, the Department has attempted to minimize the impact of the rule on insurance producers and independent insurance adjusters by including language that states that an agent, representative, or designee of an insurer, a corporation, an HMO, or a provider, who is regulated pursuant to the Insurance Law, need not develop its own confidentiality protocol if the agent, representative, or designee follows the protocol of the insurer, corporation, HMO, or provider. Nor does a producer or an adjuster who follows the protocol of the insurer, corporation, HMO, or provider need to post certain information on its website.

3. Professional services: The rule would not require an insurance producer or independent insurance adjuster to use professional services.

4. Compliance costs: The rule will not impose any compliance costs on local governments. Insurance producers and independent insurance adjusters, many of whom are small businesses, may incur additional costs of compliance, but they should be minimal. The cost to a producer or an adjuster will be associated primarily with developing and implementing a confidentiality protocol, unless the producer or adjuster chooses to follow the protocol of the insurer, corporation, HMO, or provider.

5. Economic and technological feasibility: Local governments will not incur an economic or technological impact as a result of this rule. Insurance producers and independent insurance adjusters, many of whom are small businesses, will not have to purchase any new technology to comply with the rule.

6. Minimizing adverse impact: The rule applies to the insurance market throughout New York State. In accordance with Insurance Law § 2612, the same requirements will apply to all insurance producers and independent insurance adjusters, so the rule does not impose any adverse or disparate impact on small businesses. Further, the Department has designed the regulation to place the least burden possible on an insurance producer or insurance adjuster by allowing the producer or adjuster to follow the protocol of the insurer, corporation, HMO, or provider, rather than develop its own protocol.

7. Small business and local government participation: A proposed rule was published in the State Register on October 9, 2013, and the Department invited public comments on the rule from all interested parties including small businesses and local governments.

#### **Rural Area Flexibility Analysis**

1. Types and estimated numbers of rural areas: Insurers, insurance producers, and independent insurance adjusters affected by this rule operate in every county in this state, including rural areas as defined under State Administrative Procedure Act (“SAPA”) § 102(10).

2. Reporting, recordkeeping and other compliance requirements; and professional services: The rule requires insurers located in rural areas (as Insurance Law § 2612 defines that term, which includes health maintenance organizations as well as agents, representatives, and designees of the insurers who are regulated under the Insurance Law) to develop and implement confidentiality protocols that include written procedures that their employees, agents, representatives, or any other persons with whom the insurers contract or who have gained access to the information from the insurers, with regard to the solicitation, negotiation, or sale of insurance or the adjustment or administration of insurance claims, must follow. The rule also requires insurers to post certain information on their websites.

However, the Department has attempted to minimize the impact of the rule on insurance producers and independent insurance adjusters located in rural areas by including language that states that an agent, representa-

tive, or designee of an insurer, a corporation, an HMO, or a provider, who is regulated pursuant to the Insurance Law, need not develop its own confidentiality protocol if the agent, representative, or designee follows the protocol of the insurer, corporation, HMO, or provider. Nor does a producer or an adjuster who follows the protocol of the insurer, corporation, HMO, or provider need to post certain information on its website.

The rule would not require an insurer, insurance producer, or independent insurance adjuster located in a rural area to use professional services.

3. Costs: Insurers, insurance producers, and independent insurance adjusters located in rural areas may incur additional costs of compliance, but they should be minimal. The cost to an insurer, producer, or adjuster located in rural areas will be associated primarily with developing and implementing a confidentiality protocol. However, a producer or adjuster may choose to follow the protocol of the insurer, corporation, HMO, or provider.

4. Minimizing adverse impact: The rule applies to the insurance market throughout New York State. In accordance with Insurance Law § 2612, the same requirements will apply to all insurers, insurance producers, and independent insurance adjusters, so the rule does not impose any adverse or disparate impact on insurers, insurance producers, or independent insurance adjusters in rural areas.

5. Rural area participation: A proposed rule was published in the State Register on October 9, 2013, and the Department invited public comments on the rule from all interested parties including those located in rural areas.

#### **Job Impact Statement**

The Department of Financial Services finds that this rule should have no impact on jobs and employment opportunities. As required by Insurance Law § 2612, the rule establishes certain limited requirements to guide and enable insurers to guard against the disclosure of the confidential information protected by § 2612.

#### **Assessment of Public Comment**

The New York State Department of Financial Services (“Department”) received comments from an organization that represents the New York family planning provider network (“family planning organization”), an organization that represents people living with HIV/AIDS (“HIV organization”), an organization that works to defend constitutional rights (“civil liberties organization”), a trade organization that represents property/casualty insurers (“property/casualty trade organization”), and an organization that represents United States insurers (“insurer trade organization”), in response to its publication of the proposed rule in the New York State Register.

Comments on specific parts of the proposed rule are discussed below.

#### **11 NYCRR 244.2 (“Definitions”)**

##### **Comment**

The family planning organization, HIV organization, and civil liberties organization commented that the Department should expand the rule to apply to more than just domestic violence by defining “endanger” to encompass concerns that an insured individual’s privacy or confidentiality could be compromised if he or she did not receive communications and claim-related information at an alternate address. These organizations also commented that the Department should amend the definition of “requestor” to include a minor who is able to consent or has consented to health care services under the law.

##### **Department’s Response**

The Department is considering whether to make any change in the context of adopting the permanent rule.

#### **11 NYCRR 244.3 (“Delivers”)**

##### **Comment**

The insurer trade organization stated that consistent with statutory law, this section requires that the victim deliver to the insurer’s home office a valid order of protection issued by a court of competent jurisdiction in New York, and recommended clarifying that “deliver” does not require physical delivery to the insurer’s home office.

##### **Department’s Response**

This term comes directly from the statute. To effectuate the intent and goals of the statute, the Department construes the term broadly to mean delivery to the insurer by any means, including mail, email, or otherwise. The Department is considering whether to clarify the text of the rule in the context of adopting the permanent rule.

#### **11 NYCRR 244.3(a) (“Covered Services”)**

##### **Comment**

The property/casualty trade organization and insurer trade organization noted that this provision requires insurers to keep certain information confidential for “a person providing covered services to the victim”, and commented that there is confusion as to what this might mean in the property/casualty insurance context. The organization suggested that the Department add clarifying language if this provision is not intended to apply to property/casualty insurers.

##### **Department’s Response**

The Department construes this to mean any benefit or service provided under the policy to the victim. For example, this could be information about a medical provider under a no-fault or workers' compensation claim or the name and address of a body shop under an automobile claim. The Department is considering whether to clarify the text of the rule in the context of adopting the permanent rule.

11 NYCRR 244.3(c) and (d) ("Contractor Notification")

Comment

The insurer trade organization commented that the broad scope of these subdivisions was extremely troublesome because insurers contract with numerous vendors and many of these vendors are not in a position to be able to divulge any of the victim's information or to change the address of the victim. The organization recommended revising these subdivisions to limit their applicability solely to employees and draft a new section that clearly outlines the responsibilities of and expectations for insurance producers.

Department's Response

The Department revised a prior version of the emergency rule and the proposed rule to address this comment by adding language that makes it clear that the subdivisions apply to employees, agents, representatives, or persons who have or may have access to the information sought to be kept confidential.

11 NYCRR 244.3(c)(4) ("Personal Identifiers")

Comment

The insurer trade organization noted that this paragraph requires an insurer's written procedures to include the procedure for limiting or removing personal identifiers before information is used or disclosed, and commented that it is unclear what would constitute "limiting or removing personal identifiers."

Department's Response

The Department thinks that it is clear that limiting or removing personal identifiers means limiting or removing, such as by redacting, any information that could identify the victim or covered individual. Therefore, the Department did not make any changes to the rule to address this comment.

11 NYCRR 244.3(h) ("Hampering this Rule")

Comment

The insurer trade organization noted that the rule contained language stating that an insurer or any person subject to the Insurance Law may not engage in any practice that would prevent or hamper the orderly working of the rule in accomplishing its intended purpose of protecting victims of domestic violence and covered individuals. The organization commented that it is unclear how a person would prevent or hamper the orderly working of the rule.

Department's Response

The Department deleted this language in a prior version of the emergency rule and the proposed rule and relettered section 244.3 of the rule.

11 NYCRR 244.4 ("Notice")

Comment

The insurer trade organization suggested that the Department amend the rule to require that an insurer include a simple disclosure on the "contact us" or privacy page of the insurer's website rather than on the homepage of the insurer's website.

Department's Response

The rule requires an insurer to post on its website certain information. It does not require that information be posted on homepage of the insurer's website. Therefore, the Department did not make any changes to the rule to address this comment.

Applicability to Property/Casualty Insurers

Comment

The property/casualty trade organization commented that there are a number of areas throughout the rule in which it is unclear whether the language applies to property/casualty insurers, and gave the example of where the rule refers to a "victim or covered individual." The organization suggested that clarifying the rule's applicability would reduce confusion and facilitate compliance.

Department's Response

When the rule applies to all insurers, including property/casualty insurers, the rule uses the term "insurer" as defined in Insurance Law section 2612(c)(2). When the rule applies to just a health insurer, the rule uses that term (which Insurance Law section 2612(h)(1)(B) defines). In addition, the rule clearly defines "covered individual" as applying to an individual covered under a policy issued by a health insurer only. The rule also defines "victim" as having the meaning set forth in Social Services Law section 459-a(1), which applies generally and does not distinguish between kinds of insurance. Therefore, the Department did not make any changes to the rule to address this comment.

Comment

The insurer trade organization commented that the legislative history of Insurance Law section 2612 indicates a clear focus on medical information and health insurers and therefore, the rule should not apply to

property/casualty insurance. The organization also suggested that if the rule applies to property/casualty insurance, then it should exclude certain commercial lines policies.

Department's Response

Insurance Law section 2612(c)(2) defines "insurer" as an insurer, an Insurance Law Article 43 corporation, a municipal cooperative health benefit plan, a health maintenance organization, a provider issued a special certificate of authority pursuant to the Public Health Law, or an agent, representative, or designee thereof regulated pursuant to the Insurance Law. This definition is not limited to health insurers or personal lines insurance.

This rule merely implements Insurance Law section 2612 and cannot narrow its applicability. Therefore, the Department did not make any changes to the rule to address these comments. Moreover, medical information is often involved in property/casualty policies, such as under no-fault or workers' compensation insurance, and is not limited to strictly health insurance or personal lines.

Alternate Contact Information

Comment

The insurer trade organization commented that it cannot find any statutory requirement that property/casualty insurers establish a procedure to accept an alternate address for domestic violence victims. However, the organization stated that it would be willing to have the rule establish an alternate contact information requirement for property/casualty medical claims payments to such victims.

Department's Response

The requirement is implicit in the law. Insurance Law section 2612(f) and (g) state that if a person covered under an insurance policy delivers to an insurer an order of protection against the policyholder or another person covered under the policy, then the insurer may not disclose to the policyholder or other covered person the address or telephone number of the victim or of any person providing covered services to the victim. This language presumes that the victim already is using an alternate address or telephone number otherwise there would be no reason to keep it confidential from the policyholder or other covered person. Therefore, the Department did not make any changes to the rule to address this comment. Nor is there any basis in the law to limit the rule to medical claims.

Joint Policy Confidentiality

Comment

The property/casualty trade organization commented that it will be difficult, and in some cases potentially impossible, to keep information confidential where the victim and the person against whom the order of protection is issued are on the same policy, such as in the homeowners' insurance context where there is joint ownership of a home.

Department's Response

As a preliminary matter, Insurance Law section 2612 requires an insurer to keep confidential certain information if the insurer receives an order of protection from an insured or other person covered under the insurance policy. This rule merely implements the legislative mandate that insurers must have confidentiality protocols in place. The association did not explain why it would be difficult or impossible to keep the victim's address and telephone number confidential from another person covered under the policy. Therefore, the Department did not make any changes to the rule to address this comment.

## EMERGENCY RULE MAKING

### Unfair Claims Settlement Practices and Claim Cost Control Measures

I.D. No. DFS-09-14-00003-E

Filing No. 148

Filing Date: 2014-02-14

Effective Date: 2014-02-14

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

**Action taken:** Amendment of Part 216 (Regulation 64) of Title 11 NYCRR.

**Statutory authority:** Financial Services Law, sections 202 and 302; and Insurance Law, sections 301 and 2601

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

**Specific reasons underlying the finding of necessity:** Insurance Law § 2601 prohibits an insurer doing business in New York State from engaging in unfair claims settlement practices and sets forth a list of acts that, if

committed without just cause and performed with such frequency as to indicate a general business practice, will constitute unfair claims settlement practices. Insurance Regulation 64 sets forth the standards insurers are expected to observe to settle claims properly.

On October 26, 2012, in anticipation of extensive power outages, loss of life and property, and ongoing harm to public health and safety expected to result from then-Hurricane Sandy, Governor Andrew M. Cuomo issued Executive Order 47, declaring a State of Disaster Emergency for all 62 counties within New York State. As anticipated, Storm Sandy struck New York State on October 29, 2012, causing extensive power outages, loss of life and property, and ongoing harm to public health and safety. In addition, a nor'easter struck New York just a week later, adding to the damage and dislocation. Many people still had not had basic services such as electric power restored before the second storm hit.

Insurers insuring property in areas that were hit the hardest by the storms, including Long Island and New York City, have a number of claims left to settle. As a result, some homeowners and small business owners have not been able to start to repair or replace their damaged property, or in some cases, complete their repairs. Moreover, there are insureds who have had their claims denied by their insurers and whose only remaining option is to file a civil suit against their insurers. Lawsuits such as these can often take years to resolve, and homeowners and small businesses can not afford to wait for the resolution of their claims in the courts.

Fair and prompt settlement of claims is critical for homeowners, a number of whom have been displaced from their homes or are living in unsafe conditions, and for small businesses, a number of which have yet to return to full operation and to recover their losses caused by the storm.

Given the nature and extent of the damage, an alternative avenue to mediate the claims would help protect the public and ensure its safety and welfare.

For the reasons stated above, the promulgation of this regulation on an emergency basis is necessary for the public health, public safety, and general welfare.

**Subject:** Unfair Claims Settlement Practices and Claim Cost Control Measures.

**Purpose:** To create a mediation program to facilitate the negotiation of certain insurance claims arising between 10/26/12 - 11/15/12.

**Text of emergency rule:** 216.13 Mediation.

(a) This section shall apply to any claim for loss or damage, other than claims made under flood policies issued under the national flood insurance program, occurring from October 26, 2012 through November 15, 2012, in the counties of Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk or Westchester, including their adjacent waters, with respect to:

- (1) loss of or damage to real property; or
- (2) loss of or damage to personal property, other than damage to a motor vehicle.

(b)(1) Except as provided in paragraph (2) of this subdivision, an insurer shall send the notice required by paragraph (3) of this subdivision to a claimant, or the claimant's authorized representative:

- (i) at the time the insurer denies a claim in whole or in part;
- (ii) within 10 business days of the date that the insurer receives notification from a claimant that the claimant disputes a settlement offer made by the insurer, provided that the difference between the positions of the insurer and claimant is \$1,000 or more; or
- (iii) within two business days when the insurer has not offered to settle within 45 days after it has received a properly executed proof of loss and all items, statements and forms that the insurer had requested from the claimant.

(2) If, prior to the effective date of this section: the insurer denied a claim in whole or in part; or a claimant disputed a settlement offer, or more than 45 days elapsed after the insurer received a properly executed proof of loss and all items, statements and forms that the insurer had requested from the claimant, and in either case the claim still remains unresolved as of the effective date of this section, then the insurer shall provide the notice required by paragraph (3) of this subdivision within ten business days from the effective date of this section.

(3) The notice specified in paragraphs (1) and (2) of this subdivision shall inform the claimant of the claimant's right to request mediation and shall provide instructions on how the claimant may request mediation, including the name, address, phone number, and fax number of an organization designated by the superintendent to provide a mediator to mediate claims pursuant to this section. The notice shall also provide the insurer's address and phone number for requesting additional information.

(c) If the claimant submits a request for mediation to the insurer, the insurer shall forward the request to the designated organization within three business days of receiving the request.

(d) The insurer shall pay the designated organization's fee for the mediation to the designated organization within five days of the insurer receiving a bill from the designated organization.

(e)(1) The mediation shall be conducted in accordance with procedures established by the designated organization and approved by the superintendent.

(2) A mediation may be conducted by face-to-face meeting of the parties, videoconference, or telephone conference, as determined by the designated organization in consultation with the parties.

(3) A mediation may address any disputed issues for a claim to which this section applies, except that a mediation shall not address and the insurer shall not be required to attend a mediation for:

(i) a dispute in property valuation that has been submitted to an appraisal process or a claim that is the subject of a civil action filed by the insured against the insurer, unless the insurer and the insured agree otherwise;

(ii) any claim that the insurer has reason to believe is a fraudulent transaction or for which the insurer has knowledge that a fraudulent insurance transaction has taken place; or

(iii) any type of dispute that the designated organization has excepted from its mediation process in accordance with the organization's procedures approved by the superintendent.

(f)(1) The insurer must participate in good faith in all mediations scheduled by the designated organization, which shall at a minimum include compliance with paragraphs (2), (3), and (4) of this subdivision.

(2) The insurer shall send a representative to the mediation who is knowledgeable with respect to the particular claim; and who has authority to make a binding claims decision on behalf of the insurer and to issue payment on behalf of the insurer. The insurer's representative must bring a copy of the policy and the entire claims file, including all relevant documentation and correspondence with the claimant.

(3) An insurer's representatives shall not continuously disrupt the process, become unduly argumentative or adversarial or otherwise inhibit the negotiations.

(4) An insurer that does not alter its original decision on the claim is not, on that basis alone, failing to act in good faith if it provides a reasonable explanation for its action.

(g) An insured's right to request mediation pursuant to this section shall not affect any other right the insured may have to redress the dispute, including remedies specified in the insurance policy, such as an insured's right to request an appraisal, the right to litigate the dispute in the courts if no agreement is reached, or any right provided by law.

(h)(1) No organization shall be designated by the superintendent unless it agrees that:

(i) the superintendent shall oversee the operational procedures of the designated organization with respect to administration of the mediation program, and shall have access to all systems, databases, and records related to the mediation program; and

(ii) the organization shall make reports to the superintendent in whatever form and as often as the superintendent prescribes.

(2) No organization shall be designated unless its procedures, approved by the superintendent, require that:

(i) the parties agree in writing prior to the mediation that statements made during the mediation are confidential and will not be admitted into evidence in any civil litigation concerning the claim, except with respect to any proceeding or investigation of insurance fraud;

(ii) a settlement agreement reached in a mediation shall be transcribed into a written agreement, on a form approved by the superintendent, that is signed by a representative of the insurer with the authority to do so and by the claimant; and

(iii) a settlement agreement prepared during a mediation shall include a provision affording the claimant a right to rescind the agreement within three business days from the date of the settlement, provided that the insured has not cashed or deposited any check or draft disbursed to the claimant for the disputed matters as a result of the agreement reached in the mediation.

(3) No organization shall be designated unless its procedures, approved by the superintendent, provide that:

(i) the mediator may terminate a mediation session if the mediator determines that either the insurer's representative or the claimant is not participating in the mediation in good faith, or if even after good faith efforts, a settlement can not be reached;

(ii) the designated organization may schedule additional mediation sessions if it believes the sessions may result in a settlement;

(iii) the designated organization may require the insurer to send a different representative to a rescheduled mediation session if the representative has not participated in good faith, the fee for which shall be paid by the insurer; and

(iv) the designated organization may reschedule a mediation session if the mediator determines that the claimant is not participating in good faith, but only if the claimant pays the organization's fee for the mediation.

**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 May 14, 2014.

**Text of rule and any required statements and analyses may be obtained from:** Brenda Gibbs, NYS Department of Financial Services, One Commerce Plaza, Albany, NY 12257, (518) 408-3451, email: [brenda.gibbs@dfs.ny.gov](mailto:brenda.gibbs@dfs.ny.gov)

#### **Regulatory Impact Statement**

1. Statutory authority: Sections 202 and 302 of the Financial Services Law and Sections 301 and 2601 of the Insurance Law. Financial Services Law § 202 grants the Superintendent of Financial Services (“Superintendent”) the rights, powers, and duties in connection with financial services and protection in this state, expressed or reasonably implied by the Financial Services Law or any other applicable law of this state. Insurance Law § 301 and Financial Services Law § 302 authorize the Superintendent to prescribe regulations interpreting the provisions of the Insurance Law and to effectuate any power granted to the Superintendent in the Insurance Law. Insurance Law § 2601 prohibits an insurer doing business in New York State from engaging in unfair claims settlement practices, sets forth certain acts that, if committed without just cause and performed with such frequency as to indicate a general business practice, constitute unfair claims settlement practices, and imposes penalties if an insurer engages in these acts. Such practices include “not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear” and “compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.”

2. Legislative objectives: As noted in the Department’s statement in support for the bill that added the predecessor section to § 2601, Section 40-d, to the Insurance Law in 1970 (Chapter 296 of the Laws of 1970), an insurance company’s obligation to deal fairly with claimants and policyholders in the settlement of claims – indeed, its simple obligation to pay claims at all – was solely a matter of private contract law. That left the Department unable to aid consumers and relegated them solely to the courts. There was a wide variety in insurers’ claims practices. Insurance Law § 2601 reflects the Legislature’s concerns with insurance claims practices of insurers. In enacting that section, the Legislature authorized the Superintendent to monitor and regulate insurance claims practices.

3. Needs and benefits: On October 26, 2012, in anticipation of extensive power outages, loss of life and property, and ongoing harm to public health and safety expected to result from then-Hurricane Sandy, Governor Andrew M. Cuomo issued Executive Order 47, declaring a State of Disaster Emergency for all 62 counties within New York State. As anticipated, Storm Sandy struck New York State on October 29, 2012, causing extensive power outages, loss of life and property, and ongoing harm to public health and safety. In addition, a nor’easter struck New York just a week later, adding to the damage and dislocation. Many people still had not had basic services such as electric power restored before the second storm hit.

Insurers insuring property in areas that were hit the hardest by the storms, including Long Island and New York City, have a number of claims left to settle. As a result, a number of homeowners and small business owners have not been able to start to repair or replace their damaged property, or in some cases, complete their repairs. Many small businesses have suffered losses of income that threaten their survival. Fair and prompt settlement of claims is critical for homeowners, many of whom who have been displaced from their homes or who are living in unsafe conditions, and for small businesses, to enable them to return to full operation and to recover their losses caused by the storm. Furthermore, many small businesses provide essential services to and a significant source of employment in the communities in which they are located.

Moreover, there are many insureds who have had their claims denied by their insurers and whose only remaining option is to file a civil suit against their insurers. Lawsuits such as these can often take years to resolve, and homeowners and small businesses can not afford to wait for the resolution of their claims in the courts.

Therefore, this rule creates a mediation program to facilitate the negotiation of certain insurance claims arising in the counties of New York, Bronx, Kings, Richmond, Queens, Nassau, Suffolk, Westchester, Rockland, and Orange, the areas that suffered the greatest storm damage, between October 26, 2012 and November 15, 2012. An insured may request mediation for a claim for loss or damage to personal or real property (1) that the insurer has denied, (2) for which the insured disputes the insurer’s settlement offer if the difference between what the insured seeks and the insurer offers is more than \$1,000, or (3) that has not been settled within 45 days after the insurer received all the information the insurer needs to decide the claim. The amendment does not provide for mediation of claims for damage to motor vehicles.

Participation in the mediation program by insureds is voluntary. Participation by insurers in the mediation program is mandatory, except that an insurer is not required to participate in a mediation for any claim involving a dispute in property valuation that has been submitted to an appraisal process or that has become the subject of civil litigation, unless the insurer and insured agree otherwise. An insurer also is not required to mediate any claim for which the insurer has reason to believe or knowledge that a fraudulent insurance transaction has taken place.

4. Costs: This rule does not impose compliance costs on state or local governments. The rule may increase costs for insurers, because they will need to pay the costs of mediation and provide representatives to send to the mediations. However, by providing an alternative to litigation, the insurers should also realize savings from mediations that result in settlements because the cost to mediate a claim is significantly less than the cost to defend against civil litigation brought by insureds. The actual cost effect of the rule is difficult to quantify because it is dependent upon unknown variables such as how many claims will be subject to litigation, how many insureds will select the mediation option, and how many claims that are mediated will be successfully resolved without the insured resorting to litigation. Nothing in this rule requires insurers to reach a settlement in the course of a mediation.

5. Local government mandates: This rule does not impose any requirement upon a city, town, village, school district, or fire district.

6. Paperwork: This rule does not impose any additional paperwork.

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

8. Alternatives: The Department considered making this rule applicable to the entire state. However, since the major concerns appeared to be localized, the applicability of the amendment is limited to those counties most impacted by the storm. In addition, the Department could have made the rule apply to all claims, even those that had been settled before the effective date of the rule. However, after meeting with industry trade groups and hearing their concerns, the Department modified the rule to make clear that, for claims that had already been made as of the rule’s effective date, only those that were denied or unresolved as of the rule’s effective date are covered by the rule. The Department also changed the rule so that it applies only to disputes where the parties’s positions are \$1,000 or more apart.

9. Federal standards: There are no minimum standards of the federal government for the same or similar subject areas. The rule is consistent with federal standards or requirements. The regulation does not apply to claims made under policies issued under the national flood insurance program.

10. Compliance schedule: Insurers will be required to comply with this rule upon the Superintendent’s filing the rule with the Secretary of State.

#### **Regulatory Flexibility Analysis**

1. Small businesses: The Department of Financial Services (“Department”) 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 insurers authorized to do business in New York State, none of which fall within the definition of a “small business” as found in State Administrative Procedure Act § 102(8). The Department has monitored annual statements and reports on examination of authorized insurers subject to this rule, and believes that none of the insurers falls within the definition of “small business” because no insurer is both independently owned and has fewer than 100 employees.

2. Local governments: The rule does not impose any impact, including any adverse impact, or reporting, recordkeeping, or other compliance requirements on any local governments. The basis for this finding is that this rule is directed at authorized insurers, which are not local governments.

#### **Rural Area Flexibility Analysis**

1. Types and estimated numbers of rural areas: “Rural areas,” as used in State Administrative Procedure Act (“SAPA”) § 102(10), means counties within the state having less than 200,000 population, and the municipalities, individuals, institutions, communities, programs and such other entities or resources as are found therein. In counties of 200,000 or greater population, “rural areas” means towns with population densities of 150 persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein. While insurers affected by this rule may be headquartered in rural areas, the rule itself only applies within the counties of New York, Bronx, Kings, Richmond, Queens, Nassau, Suffolk, Westchester, Rockland, and Orange. None of these counties is a rural area, and the Department of Financial Services (“Department”) does not believe that there are any towns within any of those counties that would be considered to be rural areas within the SAPA definition.

2. Reporting, recordkeeping and other compliance requirements, and professional services: The rule would not impose any additional reporting

or recordkeeping requirements. However, the rule would impose other compliance requirements on insurers that may be headquartered in rural areas by requiring insurers to participate in mediation sessions when an insured with a claim subject to the rule requests mediation of his or her claim.

It is unlikely that professional services would be needed in rural areas to comply with this rule.

3. Costs: The rule may result in additional costs to insurers headquartered in rural areas, because they will need to pay the costs of mediation and provide representatives to send to the mediations. However, by providing an alternative to litigation, the insurers may also realize savings from mediations that result in settlements because the cost to mediate a claim is significantly less than the cost to defend against civil litigation brought by insureds. The actual cost effect of the rule is difficult to quantify because it is dependent upon unknown variables such as how many claims will be subject to litigation, how many insureds will select the mediation option, and how many claims that are mediated will be successfully resolved without the insured resorting to litigation. Nothing in this rule requires insurers to reach a settlement in the course of a mediation.

4. Minimizing adverse impact: The Department considered the approaches suggested in SAPA § 202-bb(2) for minimizing adverse economic impacts. Because the public health, safety, or general welfare has been endangered, establishment of differing compliance or reporting requirements or timetables based upon whether or not the damage occurred in a rural area is not appropriate. However, the rule applies only in the counties of New York, Bronx, Kings, Richmond, Queens, Nassau, Suffolk, Westchester, Rockland, and Orange, the areas that suffered the greatest storm damage, and thus the impact of the rule on rural areas is minimized, since none of those counties are rural areas.

5. Rural area participation: Public and private interests in rural areas have had a continual opportunity to participate in the rule making process since the first publication of the emergency measure in the State Register on March 13, 2013, which was published again in the State Register on December 4, 2013. The emergency measure also has been posted on the Department's website continually since March 13, 2013.

#### Job Impact Statement

The Department of Financial Services does not believe that this rule will have any adverse impact on jobs or employment opportunities, including self-employment opportunities. This rule provides insureds with open or denied claims for loss or damage to personal and real property, except damage to automobiles, arising in New York, Bronx, Kings, Richmond, Queens, Nassau, Suffolk, Westchester, Rockland, and Orange counties between October 26, 2012 and November 15, 2012, with an option to participate in a mediation program to facilitate the negotiation of their claims with their insurers.

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## Department of Health

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### EMERGENCY RULE MAKING

#### Hospital Indigent Care Pool Payment Methodology

**I.D. No.** HLT-50-13-00001-E

**Filing No.** 150

**Filing Date:** 2014-02-18

**Effective Date:** 2014-02-18

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

**Action taken:** Addition of section 86-1.47 to Title 10 NYCRR.

**Statutory authority:** Public Health Law, section 2807-k(5-d)

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

**Specific reasons underlying the finding of necessity:** The proposed regulation establishes a distribution methodology for indigent care pool payments to general hospitals for the three-year period January 1, 2013 through December 31, 2015.

Public Health Law section 2807-k(5-d)(b) provides the Commissioner of Health with the authority to issue the regulation on an emergency basis. Emergency adoption of the proposed regulation with an effective date of January 1, 2013 is necessary to satisfy the statutory timeframe prescribed by Chapter 56 of the Laws of 2013 and to secure federal approval of the associated Medicaid State Plan Amendment.

The State may not begin making hospital indigent care payments using the new distribution methodology until the regulation is adopted and the associated Medicaid State Plan Amendment is approved.

**Subject:** Hospital Indigent Care Pool Payment Methodology.

**Purpose:** To establish the methodology for indigent care pool payments to general hospitals for the 3 year period 1/1/13 through 12/31/15.

**Text of emergency rule:** Subpart 86-1 of title 10 of NYCRR is amended by adding a new section 86-1.47 to read as follows:

*86-1.47 Hospital indigent care pool payments.*

(a) *Effective for periods on and after January 1, 2013, payments pursuant to subdivision 5-d of section 2807-k of the Public Health Law shall be made in accordance with the provisions of this section.*

(b) *For the purposes of distributions in accordance with this section, each hospital's relative uncompensated care need amount shall be determined in accordance with the following:*

(1) *All uninsured inpatient units of service as reported in Exhibit 32 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year, but excluding hospital-based residential health care facility ("RHCF") and hospice units of service, shall be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year.*

(2) *All uninsured outpatient units of service as reported in Exhibit 33 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year, but excluding referred ambulatory and home health services, shall be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year.*

(3) *The inpatient amounts determined pursuant to paragraph (1) of this subdivision for each hospital shall be summed and adjusted by a statewide inpatient cost adjustment factor equivalent to the aggregate sum of the inpatient uninsured units multiplied by the step-down cost per unit for each applicable inpatient service, excluding hospital-based RHCF and hospice services, for all hospitals statewide, divided by the aggregate sum of the amounts determined pursuant to paragraph (1) of this subdivision for all hospitals statewide.*

(4) *The outpatient amounts determined pursuant to paragraph (2) of this subdivision for each hospital shall be summed and adjusted by a statewide outpatient cost adjustment factor equivalent to the aggregate sum of the outpatient uninsured units multiplied by the step-down cost per unit for each applicable outpatient service, excluding referred ambulatory and home health services, for all hospitals statewide, divided by the aggregate sum of the amounts determined pursuant to paragraph (2) of this subdivision for all hospitals statewide.*

(5) *The adjusted inpatient and outpatient amounts determined pursuant to paragraphs (1) through (4) of this subdivision for each hospital shall be summed and reduced by the sum of all of the cash payments collected from such uninsured patients as reported in the Institutional Cost Report from the cost reporting year two years prior to the distribution year to determine each hospital's net adjusted uncompensated care need.*

(6) *The uncompensated care nominal need for each hospital shall be calculated as the net adjusted uncompensated care need multiplied by the sum of: (i) 0.40, and (ii) the Medicaid inpatient utilization rate multiplied by 0.60. The Medicaid inpatient utilization rate shall be calculated based on discharge data reported in Exhibit 32 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year and shall include fee-for-service and managed care discharges for acute and exempt services.*

(c) *For the 2013 calendar year, payments shall be made as follows:*

(1) *One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital ("DSH") payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than two and a half percent less than the average distributions such hospitals received pursuant to § 2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.*

(2) *Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than two and a half percent less than the average distributions such hospitals received pursuant to § 2807-k and § 2807-w of the*

Public Health Law, excluding academic medical center grants received pursuant to § 2807-k(5-b)(b)(v) of the Public Health Law, & not; and after any reductions made pursuant to § 2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(d) For the 2014 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital ("DSH") payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than five percent less than the average distributions such hospitals received pursuant to § 2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than five percent less than the average distributions such hospitals received pursuant to § 2807-k and 2807-w of the Public Health Law, excluding academic medical center grants received pursuant to § 2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to § 2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(e) For the 2015 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital ("DSH") payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than seven and a half percent less than the average distributions such hospitals received pursuant to § 2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than seven and a half percent less than the average distributions such hospitals received pursuant to § 2807-k and § 2807-w of the Public Health Law, excluding academic medical center grants received pursuant to § 2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to § 2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period

January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(f) (1) Funds reserved in the Financial Assistance Compliance Pool ("FACP") pursuant to § 2807-k(5-d)(b)(iv) of the Public Health Law for the calendar years 2014 and 2015 shall be distributed to hospitals which demonstrate substantial compliance, as determined by the Commissioner, with the provisions of § 2807-k(9-a) of the Public Health Law (the "financial assistance law" or "FAL").

(2) Hospitals which are determined to be in substantial FAL compliance by the end of the 2013 calendar year shall receive their 2014 FACP payments as soon as practical in 2014 in accordance with subdivision (b) of this section. Hospitals which are determined to be in substantial FAL compliance by the end of the 2014 calendar year shall receive their 2015 FACP funds as soon as practical in 2015 in accordance with subdivision (b) of this section, provided, however, that those hospitals which were determined to be not in such substantial compliance by the end of 2013, but which are determined to be in such substantial compliance by the end of 2014, shall receive both their 2014 and 2015 FACP payments as soon as practical in 2015.

**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. HLT-50-13-00001-P, Issue of December 11, 2013. The emergency rule will expire April 18, 2014.

**Text of rule and any required statements and analyses may be obtained from:** Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. Affairs Unit, Room 2438, ESP Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqa@health.state.ny.us

#### Regulatory Impact Statement

Statutory Authority:

The statutory authority for this regulation is contained in Section 2807-k (5-d) of the Public Health Law (PHL), as enacted by Section 1 of Part C of Chapter 56 of the Laws of 2013, which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to the establishment of a distribution methodology to make annual indigent care pool payments to general hospitals for the three-year period January 1, 2013 through December 31, 2015. The distribution methodology will be set forth in Section 86-1.47 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York.

Legislative Objectives:

The legislation requires the Department of Health to develop an indigent care distribution methodology which conforms to federal DSH ("Disproportionate Share Hospital") reform guidelines by targeting payments to hospitals which provide a disproportionate share of uncompensated care to the uninsured and Medicaid inpatient population and also to strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law. The legislation further requires that the distribution methodology be set forth in a regulation with an effective date of January 1, 2013.

The State provides over \$1.1 billion annually in hospital indigent care (DSH) payments which are funded through a fifty percent federal match. Beginning in October 2013, the federal government will begin reducing DSH payments to states that don't target their DSH payments solely to hospitals with high uncompensated care provided to the uninsured and Medicaid population. To minimize the State's share of these federal cuts and to respond to industry and public pressure to tie indigent care payments directly to care provided to the poor, the Department developed the new distribution methodology set forth in the proposed regulation.

Needs and Benefits:

The proposed regulation establishing the new indigent care distribution methodology replaces an outdated and complex distribution methodology which expired December 31, 2012.

The proposed regulation contains the detailed calculations required to determine a hospital's relative uncompensated care need, incorporating both uninsured and Medicaid inpatient volume, which forms the basis for allocation of a proportional share of the total available pool funds.

The proposed regulation also provides for a transition payment, in each of the three years 2013-2015, to ensure that no hospital experiences severe financial instability resulting from the redistribution of funding among the hospitals as a result of the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012). Hospitals which experience gains will have their distributions similarly capped by a set percentage of the average indigent care pool payments received in the previous three years (2010-2012).

In addition, the proposed regulation grants the Commissioner the

authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015 in order to strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law. Hospitals must demonstrate compliance with the provisions of the Financial Aid Law to receive their share of the one percent withheld funds for years 2014 and 2015.

The benefits of the regulatory changes include a simpler, more transparent methodology which relates indigent care pool payments directly to care of low-income patients and incentives for hospitals to comply with the provisions of the Financial Aid Law. Further, federal DSH matching funds are optimized by the State's conformance with federal guidelines.

**Costs:**

**Costs to Private Regulated Parties:**

There will be no additional costs to private regulated parties. The proposed regulation utilizes information contained in the Institutional Cost Reports which hospitals are already required to submit to the Department on an annual basis.

**Costs to State Government:**

There is no increase in Medicaid expenditures anticipated as a result of this regulation.

**Costs to Local Government:**

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

**Costs to the Department of Health:**

There will be no additional administrative costs to the Department of Health as a result of this proposed regulation.

**Local Government Mandates:**

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**

There are no new reporting requirements, forms or additional paperwork as a result of this amendment.

**Duplication:**

This proposed regulation does not duplicate any existing federal, state or local regulations.

**Alternatives:**

No significant alternatives are available. The Department developed the distribution methodology with extensive input from the industry associations representing the hospitals subject to the proposed regulation. The regulations are mandated by the terms of the recently enacted § 2807-k(5-d) of the Public Health Law.

**Federal Standards:**

State statutory provisions contained in PHL § 2807-k(5-d) establish a system of hospital indigent care payments, that exceed the minimum requirement for such payments established in federal law and the proposed regulations reflects those enhanced payment levels.

**Compliance Schedule:**

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. Hospitals must demonstrate compliance with the provisions of the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law to receive their share of the one percent withheld funds for years 2014 and 2015. There are no additional compliance efforts required by the hospitals.

**Regulatory Flexibility Analysis**

**Effect of Rule:**

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Reports, five hospitals were identified as employing fewer than 100 employees.

Some hospitals subject to this regulation may see a decrease in their indigent care payments as a result of this regulation but, as noted above, transition payments will help minimize the impact so that no hospital experiences severe financial instability as a result of the change in methodology.

Hospitals operated by local governments will be impacted in the same manner as other hospitals, but this rule will have no direct effect on local governments.

**Compliance Requirements:**

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth in Section 2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2014 and 2015. No other compliance efforts are required.

A small business regulation guide is not required.

The rule will have no direct effect on local governments.

**Professional Services:**

No new or additional professional services are required in order to comply with the proposed regulation.

**Compliance Costs:**

No additional compliance costs are anticipated as a result of this rule.

**Economic and Technological Feasibility:**

Small businesses will be able to comply with the economic and technological aspects of this rule because there are no technological requirements other than the use of existing technology, and the overall economic aspect of complying with the requirements is expected to be minimal.

**Minimizing Adverse Impact:**

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012).

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

**Small Business and Local Government Participation:**

The State filed a Federal Public Notice, published in the State Register on December 26, 2012, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include hospitals with 100 or fewer FTEs.

**Rural Area Flexibility Analysis**

**Effect on Rural Areas:**

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following eleven counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Monroe	Orange
Broome	Niagara	Saratoga
Dutchess	Oneida	Suffolk
Erie	Onondaga	

**Compliance Requirements:**

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth

in Section 2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2014 and 2015. No other compliance efforts are required.

**Professional Services:**

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

**Compliance Costs:**

No additional compliance costs are anticipated as a result of this rule.

**Minimizing Adverse Impact:**

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012).

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

**Rural Area Participation:**

The State filed a Federal Public Notice, published in the State Register on December 26, 2012, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including rural area members and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include members from rural areas.

**Job Impact Statement**

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. The proposed regulation establishes the hospital indigent care pool payment methodology for the three-year period January 1, 2013 through December 31, 2015. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities.

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## Niagara Frontier Transportation Authority

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

**Smoking**

**I.D. No.** NFT-09-14-00002-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 1151 of Title 21 NYCRR.

**Statutory authority:** Public Authorities Law, sections 1299-e(14), 1299-f(4) and (7)

**Subject:** Smoking.

**Purpose:** To clarify where at NFTA locations it is permissible to use electronic or battery-operated vapor inhalation devices.

**Text of proposed rule:** Section 1151.9 is amended to read as follows:

1151.9 Smoking.

No person shall smoke, carry or possess a lighted cigarette, cigar, pipe, match or other lighted equipment capable of causing naked flame inside any transportation facility or transportation vehicle. *No person shall use any electronic or battery operated device that is capable of delivering*

*vapor for inhalation, with or without nicotine, inside any transportation facility or transportation vehicle. No person shall smoke, carry or possess a lighted cigarette, cigar, pipe, match or other lighted equipment capable of causing naked flame, or use any electronic or battery operated device that is capable of delivering vapor for inhalation, with or without nicotine:*

- (a) within 20 feet of the main entrance to any transportation facility;
- (b) inside any covered parking area that is physically part of or connected to a transportation facility;
- (c) within 20 feet of building air intake ducts; and
- (d) within 20 feet of the storage of flammable and combustible materials.

**Text of proposed rule and any required statements and analyses may be obtained from:** Brigette R. Whitmore, Niagara Frontier Transportation Authority, 181 Ellicott Street, Buffalo, New York 14203, (716) 855-7219, email: Brigette\_Whitmore@nfta.com

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

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

**Consensus Rule Making Determination**

The Niagara Frontier Transportation Authority has determined that no person is likely to object to the rule being repealed or the rule as written for the following reasons:

- 1. Most of the changes are explanatory and/or are technical in nature.
- 2. None of the changes are controversial.

**Job Impact Statement**

The Niagara Frontier Transportation Authority has determined adoption of the proposed rule will have no impact on jobs or employment opportunities for the following reasons:

- 1. The proposed rule is the clarification of what is defined as smoking in regard to NFTA facilities. The rule does not impact hiring practices.

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## Public Service Commission

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### EMERGENCY RULE MAKING

**Readoption to Stay the Commission Order Issued October 28, 2013**

**I.D. No.** PSC-50-13-00002-E

**Filing Date:** 2014-02-18

**Effective Date:** 2014-02-18

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

**Action taken:** On 1/16/14, the PSC readopted the emergency rule staying the petition of Dynegy Danskammer, LLC in the Order Modifying Prior Order and Adopting Further Procedures, issued October 28, 2013.

**Statutory authority:** Public Service Law, sections 5(1)(b), 65(1), (2), (3), 66(1), (3), (5), (8), (10) and 70

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

**Specific reasons underlying the finding of necessity:** This action is taken on an emergency basis pursuant to State Administrative Procedure Act (SAPA) § 202(6). The modifications of the prior Order issued April 22, 2013 in Case 13-E-0012 are necessary to address the consequences of the Federal Energy Regulatory Commission's creation of the new Hudson Valley electric capacity zone. Electric rate increases expected within the new zone would adversely affect businesses, retard economic development, reduce employment opportunities and cause homeowners to experience financial stress. The modifications to the prior Order will open the possibility of returning the Danskammer generation facility to operation in the zone. If the cost of resuming electric operations at Danskammer is less than the capacity market prices that would be charged in the new zone during the interim while the completion of other projects is awaited, the return of Danskammer to service would represent an efficient market-based response to the expected near-term price spike in the zone and consequently would be of benefit to consumers. As a result, compliance of the advance notice and comment requirements of SAPA § 202(1) would be contrary to the public interest, and the modifications are necessary for the preservation of the health, safety and general welfare pursuant to SAPA § 202(6).

**Subject:** Readoption to stay the Commission Order issued October 28, 2013.

**Purpose:** Readoption to stay the Commission Order issued October 28, 2013.

**Substance of emergency rule:** The Commission, on January 22, 2014, readopted the emergency rule, for an additional 60 day time period, allowing for additional time to address the issues raised in the Order Modifying Prior Order and Adopting Further Procedures, issued October 28, 2013 in Case 12-E-0012.

**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. PSC-50-13-00002-EP, Issue of December 11, 2013. The emergency rule will expire April 18, 2014.

**Text of rule may be obtained from:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York, 12223-1350, (518) 486-6530, email: [deborah.swatling@dps.ny.gov](mailto:deborah.swatling@dps.ny.gov) An IRS employer ID no. or social security no. is required from firms or persons to be billed 25 cents per page. Please use tracking number found on last line of notice in requests.

**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 rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

**Assessment of Public Comment**

An assessment of public comment is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(13-E-0012EA2)

## PROPOSED RULE MAKING HEARING(S) SCHEDULED

### Major Water Rate Filing

**I.D. No.** PSC-09-14-00004-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 United Water New Rochelle Inc. to make various changes in the rates, charges, rules and regulations contained in its Schedule for Water Service—P.S.C. No. 1.

**Statutory authority:** Public Service Law, section 89-c(1) and (10)

**Subject:** Major water rate filing.

**Purpose:** To consider a proposal to increase combined annual base rates by about \$17.8 million or 30%.

**Public hearing(s) will be held at:** 10:30 a.m., May 19, 2014, and continuing daily as needed at Department of Public Service, Three Empire State Plaza, 3rd Fl. Hearing Rm., Albany, NY (Evidentiary Hearing)\*.

\*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](http://www.dps.ny.gov)) under Case 13-W-0539.

**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 proposals filed by United Water New Rochelle Inc. (UWNR) and United Water Westchester Inc. (UWW) (together, the “Companies”) which would increase its combined annual base rates by about \$17.80 million or approximately 30%<sup>1</sup> for the rate year ending October 31, 2015. In addition, the Companies are proposing to change from quarterly to monthly billing. The statutory suspension period for the proposed filing in Case 13-W-0539, runs through October 30, 2014.

This proceeding has been combined with Case 13-W-0564 - United Water Westchester Inc.’s rate proceeding and Case 14-W-0006 - Joint Petition of United Water Westchester Inc. and United Water New Rochelle Inc. for Approval, Pursuant to New York State Public Service Law Sections 108 and 89-h, to Merge and Become United Water Westchester Inc.

<sup>1</sup> Taking into account resetting the Companies’ current surcharges to zero,

the net customer impact will be an increase of approximately \$14.35 million, or approximately 23%.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: [Deborah.Swatling@dps.ny.gov](mailto:Deborah.Swatling@dps.ny.gov)

**Data, views or arguments may be submitted to:** Kathleen H. Burgess, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-4535, email: [secretary@dps.ny.gov](mailto: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.

(13-W-0539SP1)

## PROPOSED RULE MAKING HEARING(S) SCHEDULED

### Major Water Rate Filing

**I.D. No.** PSC-09-14-00007-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 United Water Westchester Inc. to make various changes in the rates, charges, rules and regulations contained in its Schedule for Water Service — P.S.C. No. 1.

**Statutory authority:** Public Service Law, section 89-c(1) and (10)

**Subject:** Major water rate filing.

**Purpose:** To consider a proposal to increase combined annual base rates by about \$17.8 million or 30%.

**Public hearing(s) will be held at:** 10:30 a.m., May 19, 2014 and continuing daily as needed, at Department of Public Service, Three Empire State Plaza, 3rd Fl. Hearing Rm., Albany, NY (Evidentiary Hearing)\*.

\*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](http://www.dps.ny.gov)) under Case 13-W-0564.

**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 United Water Westchester Inc. (UWW) and United Water New Rochelle Inc. (UWNR) (together, the “Companies”) which would increase its combined annual base rates by about \$17.80 million or approximately 30%<sup>1</sup> for the rate year ending October 31, 2015. In addition, the Companies are proposing to change from quarterly to monthly billing. The statutory suspension period for the proposed filing in Case 13-W-0564, runs through December 4, 2014.

This proceeding is combined with Case 13-W-0539 - United Water New Rochelle Inc.’s rate proceeding and Case 14-W-0006 - Joint Petition of United Water Westchester Inc. and United Water New Rochelle Inc. for Approval, Pursuant to New York State Public Service Law Sections 108 and 89-h, to Merge and Become United Water Westchester Inc.

<sup>1</sup> Taking into account resetting current surcharges at UWW to zero, the net customer impact will be an increase of approximately \$14.35 million, or approximately 23%.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: [Deborah.Swatling@dps.ny.gov](mailto:Deborah.Swatling@dps.ny.gov)

**Data, views or arguments may be submitted to:** Kathleen H. Burgess,

Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-4535, 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.  
 (13-W-0564SP1)

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

**Gas Growth Collaborative Report**

**I.D. No.** PSC-09-14-00005-P

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

**Proposed Action:** The Public Service Commission is considering whether to approve or reject, in whole or in part, the proposed recommendations from the Gas Growth Collaborative Report filed by Niagara Mohawk Power Corporation d/b/a National Grid.

**Statutory authority:** Public Service Law, section 66

**Subject:** Gas Growth Collaborative Report.

**Purpose:** To approve or reject, in whole or in part, the proposed recommendations from the Gas Growth Collaborative Report.

**Substance of proposed rule:** The Commission is considering whether to grant, deny or clarify, in whole or in part, the recommendations in the National Grid Gas Growth Collaborative Report filed by the Niagara Mohawk Power Corporation d/b/a National Grid regarding the: (a) Oil-to-Gas Rebate Program; (b) Pipeline Capacity Constraints; (c) Gas Expansion Pilot Program; and (d) CNG/LNG Vehicle Programs.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: Deborah.Swatling@dps.ny.gov

**Data, views or arguments may be submitted to:** Kathleen H. Burgess, 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.

(12-G-0202SP4)

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

**Elimination of Underutilized Lighting Options**

**I.D. No.** PSC-09-14-00006-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, in whole or in part, a proposal filed by Central Hudson Gas and Electric Corporation to make changes to its rates, charges, rules and regulations contained in PSC No. 15—Electricity.

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

**Subject:** Elimination of underutilized lighting options.

**Purpose:** To eliminate underutilized lighting options in Area Lighting Service and Public Street and Highway Lighting.

**Substance of proposed rule:** The Commission is considering whether to approve, modify or reject, in whole or in part, a tariff filing by Central Hudson Gas and Electric Corporation (the Company) to modify lighting options contained in its electric schedule P.S.C. No. 15—Electricity. The Company proposes to eliminate underutilized lighting options under Ser-

vice Classification (SC) No. 5 — Area Lighting Service and SC No. 8—Public Street and Highway Lighting for new installations and replacements, thereby reducing the number of different fixture options. The proposed filing has an effective date of June 1, 2014.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: Deborah.Swatling@dps.ny.gov

**Data, views or arguments may be submitted to:** Kathleen H. Burgess, 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.

(14-E-0059SP1)

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

**Waiver of 16 NYCRR Sections 894.1 Through 894.4(b)(2)**

**I.D. No.** PSC-09-14-00008-P

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

**Proposed Action:** The Public Service Commission is considering to approve, modify, or reject a petition from the Town of Scipio, Cayuga County, to waive 16 NYCRR sections 894.1 through 894.4 pertaining to the franchising process.

**Statutory authority:** Public Service Law, section 216(1)

**Subject:** Waiver of 16 NYCRR sections 894.1 through 894.4(b)(2).

**Purpose:** To allow the Town of Scipio, NY, to waive certain preliminary franchising procedures to expedite the franchising process.

**Substance of proposed rule:** The Public Service Commission is considering whether to approve, modify, or reject the Petition of the Town of Scipio, Cayuga County, to waive the requirements of 16 NYCRR, sections 894.1 through 894.4 to expedite the franchising process.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: Deborah.Swatling@dps.ny.gov

**Data, views or arguments may be submitted to:** Kathleen H. Burgess, 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.

(14-V-0047SP1)

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

**To Consider Acquiring Cable Television Facilities and Franchises of Towns of Greene and Smithville by TWC by Haeefe TV, Inc.**

**I.D. No.** PSC-09-14-00009-P

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

**Proposed Action:** The Public Service Commission is considering a petition from Time Warner Cable Northeast LLC (TWC) to acquire cable

television facilities and franchises in the Towns of Greene and Smithville from Haeefe TV, Inc.

**Statutory authority:** Public Service Law, section 222

**Subject:** To consider acquiring cable television facilities and franchises of Towns of Greene and Smithville by TWC by Haeefe TV, Inc.

**Purpose:** To allow TWC to distribute cable television facilities and franchises of the Towns of Greene and Smithville by Haeefe TV, Inc.

**Substance of proposed rule:** The Public Service Commission is considering the acquisition of certain cable television facilities and franchises in the Towns of Greene and Smithville to Time Warner Cable Northeast LLC from Haeefe TV, Inc., in accordance with Section 222 regarding transfer, renewal, or amendment of franchises and transfer of control over franchises and system properties.

**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.ny.gov/f96dir.htm>. For questions, contact:** Deborah Swatling, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2659, email: Deborah.Swatling@dps.ny.gov

**Data, views or arguments may be submitted to:** Kathleen H. Burgess, 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.

(14-V-0023SP1)

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## Department of Taxation and Finance

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### NOTICE OF ADOPTION

**Fuel Use Tax on Motor Fuel and Diesel Motor Fuel and the Art. 13-A Carrier Tax Jointly Administered Therewith**

**I.D. No.** TAF-50-13-00003-A

**Filing No.** 146

**Filing Date:** 2014-02-13

**Effective Date:** 2014-02-13

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

**Action taken:** Amendment of section 492.1(b)(1) of Title 20 NYCRR.

**Statutory authority:** Tax Law, sections 171, subd. First, 301-h(c), 509(7), 523(b) and 528(a)

**Subject:** Fuel use tax on motor fuel and diesel motor fuel and the art. 13-A carrier tax jointly administered therewith.

**Purpose:** To set the sales tax component and the composite rate per gallon for the period January 1, 2014 through March 31, 2014.

**Text or summary was published** in the December 11, 2013 issue of the Register, I.D. No. TAF-50-13-00003-P.

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

**Text of rule and any required statements and analyses may be obtained from:** Thomas E. Curry, Tax Regulations Specialist 4, Department of Taxation and Finance, Taxpayer Guidance, Building 9, W.A. Harriman Campus, Albany, NY 12227, (518) 530-4145, email: ax.regulations@tax.ny.gov

**Assessment of Public Comment**

An assessment of public comment is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

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

**Fuel Use Tax on Motor Fuel and Diesel Motor Fuel and the Art. 13-A Carrier Tax Jointly Administered Therewith**

**I.D. No.** TAF-09-14-00001-P

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

**Proposed Action:** Amendment of section 492.1(b)(1) of Title 20 NYCRR.

**Statutory authority:** Tax Law, sections 171, subd. First, 301-h(c), 509(7), 523(b) and 528(a)

**Subject:** Fuel use tax on motor fuel and diesel motor fuel and the art. 13-A carrier tax jointly administered therewith.

**Purpose:** To set the sales tax component and the composite rate per gallon for the period April 1, 2014 through June 30, 2014.

**Text of proposed rule:** Section 1. Paragraph (1) of subdivision (b) of section 492.1 of such regulations is amended by adding a new subparagraph (lxxiv) to read as follows:

Motor Fuel			Diesel Motor Fuel		
Sales Tax Component	Composite Rate	Aggregate Rate	Sales Tax Component	Composite Rate	Aggregate Rate
(lxxiii) January-March 2014					
16.0	24.0	42.4	16.0	24.0	40.65
(lxxiv) April-June 2014					
16.0	24.0	42.4	16.0	24.0	40.65

**Text of proposed rule and any required statements and analyses may be obtained from:** Thomas E. Curry, Tax Regulations Specialist 4, Department of Taxation and Finance, Taxpayer Guidance, Building 9, W.A. Harriman Campus, Albany, NY 12227, (518) 530-4145, email: tax.regulations@tax.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, 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.