

Assessment of Public Comments on the Proposed First Amendment to Insurance Regulation 193 (11 NYCRR 58).

The New York State Department of Financial Services (“Department”) received comments from one insurer.

Comment: The insurer requested the Department to amend sections 58.1(d)(3) and 58.4(c)(6) of 11 NYCRR to clarify that insurers shall not be authorized to offer plans C, F, or high deductible plan F+ to individuals who are newly eligible for Medicare on or after January 1, 2020.

Response: No revisions were made to the proposed rulemaking in response to this comment because the existing language is already clear.

Comment: The insurer requested the Department to amend sections 58.1(d)(3) and 58.4(c)(6) to replace the word “may” with “shall” with respect to the offer of plan C or F to non-newly eligible individuals where the effective date is on or after January 1, 2020. The insurer contends that the availability of either Plan C or Plan F for non-newly eligible individuals is guaranteed by 42 U.S. Code 1395ss(o)(5) and section 9.1A(2) of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (“Model Act”) if the insurer is offering both plans A and B as required by 11 NYCRR 58.1(d)(3) & 58.4(b)(7)(i)-(iii).

Response: The Department made the requested clarifying revisions to sections 58.1(d)(3) and 58.4(b)(7)(ii) by replacing the word “may” with “shall”.

Comment: The insurer commented that sections 58.1(d)(3), 58.4(b)(7)(ii), and 58.4(b)(7)(iii) refer to eligibility for Medicare rather than Medicare Part A and based on “age or disability” rather than cite to the federal Medicare statutes. The insurer commented that the Department should adopt the more specific references used in 42 U.S. Code 1395ss(z)(2) and section 9.2B of the Model Act to remove any possible ambiguity as to who may purchase plans C or F.

Response: No revisions were made to the proposed rulemaking in response to this comment because

the existing language is already clear.

Comment: The insurer commented that section 58.4(c)(8) should state that the high deductible plan G+ pays 100% of covered expenses following payment of the annual high deductible. The insurer also commented that to clarify that standardization requirements are met, section 58.4(c)(8) should include the statement from section 9.2A(4) of the Model Act that the Medicare Part B deductible paid by the beneficiary is considered an out-of-pocket expense for purposes of meeting the annual high deductible.

Response: The Department made the requested clarifying revisions to section 58.4(c)(8).