SB2501

LRB10117159BMS66560b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB2501

Introduced 1/28/2020, by Sen. Laura M. Murphy

SYNOPSIS AS INTRODUCED:

215 ILCS 5/363 from Ch. 73, par. 975

Amends the Illinois Insurance Code. Provides that a Medicare supplement policyholder is entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. Provides that, during the open enrollment period, an issuer of a Medicare supplement policy shall not deny or condition the issuance or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. Requires an issuer to notify a policyholder of his or her rights under this subsection at least 30 days and no more than 60 days before the beginning of the open enrollment period, and on any notice related to a benefit modification or premium adjustment.

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A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 363 as follows:

(215 ILCS 5/363) (from Ch. 73, par. 975)

Sec. 363. Medicare supplement policies; minimum standards.

(1) Except as otherwise specifically provided therein, this Section and Section 363a of this Code shall apply to:

(a) all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this State on and after January 1, 1989; and

(b) all certificates issued under group Medicare supplement policies or subscriber contracts, which certificates are issued or issued for delivery in this State on and after January 1, 1989.

This Section shall not apply to "Accident Only" or "Specified Disease" types of policies. The provisions of this Section are not intended to prohibit or apply to policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies or plans are not marketed or purported or held to be Medicare supplement policies or benefit plans.

(2) For the purposes of this Section and Section 363a, the following terms have the following meanings:

(a) "Applicant" means:

(i) in the case of individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(ii) in the case of a group Medicare policy or subscriber contract, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

(c) "Medicare supplement policy" means an individual policy of accident and health insurance, as defined in paragraph (a) of subsection (2) of Section 355a of this Code, or a group policy or certificate delivered or issued for delivery in this State by an insurer, fraternal benefit society, voluntary health service plan, or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or a policy issued under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), or any similar organization, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(d) "Issuer" includes insurance companies, fraternal benefit societies, voluntary health service plans, health maintenance organizations, or any other entity providing Medicare supplement insurance, unless the context clearly indicates otherwise.

(e) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965.

(3) No Medicare supplement insurance policy, contract, or certificate, that provides benefits that duplicate benefits provided by Medicare, shall be issued or issued for delivery in this State after December 31, 1988. No such policy, contract, or certificate shall provide lesser benefits than those required under this Section or the existing Medicare Supplement Minimum Standards Regulation, except where duplication of Medicare benefits would result.

(4) Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded directly to him or her in a timely manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(5) A Medicare supplement policy or certificate may not deny a claim for losses incurred more than 6 months from the

effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(6) An issuer of a Medicare supplement policy shall:

(a) not deny coverage to an applicant under 65 years of age who meets any of the following criteria:

(i) becomes eligible for Medicare by reason of disability if the person makes application for a Medicare supplement policy within 6 months of the first day on which the person enrolls for benefits under Medicare Part B; for a person who is retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a 6-month period beginning with the month in which the person received notice of retroactive eligibility to enroll;

(ii) has Medicare and an employer group health plan (either primary or secondary to Medicare) that terminates or ceases to provide all such supplemental health benefits;

(iii) is insured by a Medicare Advantage plan that includes a Health Maintenance Organization, a

Preferred Provider Organization, and a Private Fee-For-Service or Medicare Select plan and the applicant moves out of the plan's service area; the insurer goes out of business, withdraws from the market, or has its Medicare contract terminated; or the plan violates its contract provisions or is misrepresented in its marketing; or

(iv) is insured by a Medicare supplement policy and the insurer goes out of business, withdraws from the market, or the insurance company or agents misrepresent the plan and the applicant is without coverage;

(b) make available to persons eligible for Medicare by reason of disability each type of Medicare supplement policy the issuer makes available to persons eligible for Medicare by reason of age;

(c) not charge individuals who become eligible for Medicare by reason of disability and who are under the age of 65 premium rates for any medical supplemental insurance benefit plan offered by the issuer that exceed the issuer's highest rate on the current rate schedule filed with the Division of Insurance for that plan to individuals who are age 65 or older; and

(d) provide the rights granted by items (a) through (d), for 6 months after the effective date of this amendatory Act of the 95th General Assembly, to any person

who had enrolled for benefits under Medicare Part B prior to this amendatory Act of the 95th General Assembly who otherwise would have been eligible for coverage under item (a).

(7) The Director shall issue reasonable rules and regulations for the following purposes:

(a) To establish specific standards for policy provisions of Medicare policies and certificates. The standards shall be in accordance with the requirements of this Code. No requirement of this Code relating to minimum required policy benefits, other than the minimum standards contained in this Section and Section 363a, shall apply to Medicare ~~medicare~~ supplement policies and certificates. The standards may cover, but are not limited to the following:

(A) Terms of renewability.

(B) Initial and subsequent terms of eligibility.

(C) Non-duplication of coverage.

(D) Probationary and elimination periods.

(E) Benefit limitations, exceptions and reductions.

(F) Requirements for replacement.

(G) Recurrent conditions.

(H) Definition of terms.

(I) Requirements for issuing rebates or credits to policyholders if the policy's loss ratio does not

comply with subsection (7) of Section 363a.

(J) Uniform methodology for the calculating and reporting of loss ratio information.

(K) Assuring public access to loss ratio information of an issuer of Medicare supplement insurance.

(L) Establishing a process for approving or disapproving proposed premium increases.

(M) Establishing a policy for holding public hearings prior to approval of premium increases.

(N) Establishing standards for Medicare Select policies.

(O) Prohibited policy provisions not otherwise specifically authorized by statute that, in the opinion of the Director, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy or certificate.

(b) To establish minimum standards for benefits and claims payments, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies.

(c) To implement transitional requirements of Medicare supplement insurance benefits and premiums of Medicare supplement policies and certificates to conform to Medicare program revisions.

(8) A Medicare supplement policyholder is entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, an issuer of a Medicare supplement policy shall not deny or condition the issuance or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of his or her rights under this subsection at least 30 days and no more than 60 days before the beginning of the open enrollment period, and on any notice related to a benefit modification or premium adjustment.

(Source: P.A. 95-436, eff. 6-1-08.)