Sen. Laura M. Murphy

Filed: 4/27/2021

1 AMENDMENT TO SENATE BILL 147

2 AMENDMENT NO. ______. Amend Senate Bill 147 by replacing
3 everything after the enacting clause with the following:

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

6 (215 ILCS 5/363) (from Ch. 73, par. 975)
7 Sec. 363. Medicare supplement policies; minimum standards.
8 (1) Except as otherwise specifically provided therein,
9 this Section and Section 363a of this Code shall apply to:
10 (a) all Medicare supplement policies and subscriber
11 contracts delivered or issued for delivery in this State
12 on and after January 1, 1989; and
13 (b) all certificates issued under group Medicare
14 supplement policies or subscriber contracts, which
15 certificates are issued or issued for delivery in this
16 State on and after January 1, 1989.

1 This Section shall not apply to "Accident Only" or
2 "Specified Disease" types of policies. The provisions of this
3 Section are not intended to prohibit or apply to policies or
4 health care benefit plans, including group conversion
5 policies, provided to Medicare eligible persons, which
6 policies or plans are not marketed or purported or held to be
7 Medicare supplement policies or benefit plans.
8 (2) For the purposes of this Section and Section 363a, the
9 following terms have the following meanings:
10 (a) "Applicant" means:
11 (i) in the case of individual Medicare supplement
12 policy, the person who seeks to contract for insurance
13 benefits, and
14 (ii) in the case of a group Medicare policy or
15 subscriber contract, the proposed certificate holder.
16 (b) "Certificate" means any certificate delivered or
17 issued for delivery in this State under a group Medicare
18 supplement policy.
19 (c) "Medicare supplement policy" means an individual
20 policy of accident and health insurance, as defined in
21 paragraph (a) of subsection (2) of Section 355a of this
22 Code, or a group policy or certificate delivered or issued
23 for delivery in this State by an insurer, fraternal
24 benefit society, voluntary health service plan, or health
25 maintenance organization, other than a policy issued
26 pursuant to a contract under Section 1876 of the federal

1 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
2 policy issued under a demonstration project specified in
3 42 U.S.C. Section 1395ss(g)(1), or any similar
4 organization, that is advertised, marketed, or designed
5 primarily as a supplement to reimbursements under Medicare
6 for the hospital, medical, or surgical expenses of persons
7 eligible for Medicare.
8 (d) "Issuer" includes insurance companies, fraternal
9 benefit societies, voluntary health service plans, health
10 maintenance organizations, or any other entity providing
11 Medicare supplement insurance, unless the context clearly
12 indicates otherwise.
13 (e) "Medicare" means the Health Insurance for the Aged
14 Act, Title XVIII of the Social Security Amendments of
15 1965.
16 (3) No Medicare supplement insurance policy, contract, or
17 certificate, that provides benefits that duplicate benefits
18 provided by Medicare, shall be issued or issued for delivery
19 in this State after December 31, 1988. No such policy,
20 contract, or certificate shall provide lesser benefits than
21 those required under this Section or the existing Medicare
22 Supplement Minimum Standards Regulation, except where
23 duplication of Medicare benefits would result.
24 (4) Medicare supplement policies or certificates shall
25 have a notice prominently printed on the first page of the
26 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

1 month in which the person received notice of
2 retroactive eligibility to enroll;
3 (ii) has Medicare and an employer group health
4 plan (either primary or secondary to Medicare) that
5 terminates or ceases to provide all such supplemental
6 health benefits;
7 (iii) is insured by a Medicare Advantage plan that
8 includes a Health Maintenance Organization, a
9 Preferred Provider Organization, and a Private
10 Fee-For-Service or Medicare Select plan and the
11 applicant moves out of the plan's service area; the
12 insurer goes out of business, withdraws from the
13 market, or has its Medicare contract terminated; or
14 the plan violates its contract provisions or is
15 misrepresented in its marketing; or
16 (iv) is insured by a Medicare supplement policy
17 and the insurer goes out of business, withdraws from
18 the market, or the insurance company or agents
19 misrepresent the plan and the applicant is without
20 coverage;
21 (b) make available to persons eligible for Medicare by
22 reason of disability each type of Medicare supplement
23 policy the issuer makes available to persons eligible for
24 Medicare by reason of age;
25 (c) not charge individuals who become eligible for
26 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.

1 (D) Probationary and elimination periods.
2 (E) Benefit limitations, exceptions and
3 reductions.
4 (F) Requirements for replacement.
5 (G) Recurrent conditions.
6 (H) Definition of terms.
7 (I) Requirements for issuing rebates or credits to
8 policyholders if the policy's loss ratio does not
9 comply with subsection (7) of Section 363a.
10 (J) Uniform methodology for the calculating and
11 reporting of loss ratio information.
12 (K) Assuring public access to loss ratio
13 information of an issuer of Medicare supplement
14 insurance.
15 (L) Establishing a process for approving or
16 disapproving proposed premium increases.
17 (M) Establishing a policy for holding public
18 hearings prior to approval of premium increases.
19 (N) Establishing standards for Medicare Select
20 policies.
21 (O) Prohibited policy provisions not otherwise
22 specifically authorized by statute that, in the
23 opinion of the Director, are unjust, unfair, or
24 unfairly discriminatory to any person insured or
25 proposed for coverage under a medicare supplement
26 policy or certificate.

1 (b) To establish minimum standards for benefits and
2 claims payments, marketing practices, compensation
3 arrangements, and reporting practices for Medicare
4 supplement policies.
5 (c) To implement transitional requirements of Medicare
6 supplement insurance benefits and premiums of Medicare
7 supplement policies and certificates to conform to
8 Medicare program revisions.
9 (8) If an individual is at least 65 years of age but no
10 more than 75 years of age and has an existing Medicare
11 supplement policy, the individual is entitled to an annual
12 open enrollment period lasting 45 days, commencing with the
13 individual's birthday, and the individual may purchase any
14 Medicare supplement policy with the same issuer that offers
15 benefits equal to or lesser than those provided by the
16 previous coverage. During this open enrollment period, an
17 issuer of a Medicare supplement policy shall not deny or
18 condition the issuance or effectiveness of Medicare
19 supplemental coverage, nor discriminate in the pricing of
20 coverage, because of health status, claims experience, receipt
21 of health care, or a medical condition of the individual. An
22 issuer shall provide notice of this annual open enrollment
23 period for eligible Medicare supplement policyholders at the
24 time that the application is made for a Medicare supplement
25 policy or certificate. The notice shall be in a form that may
26 be prescribed by the Department.

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

2 Section 99. Effective date. This Act takes effect on
3 January 1, 2022.".