



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB2775

Introduced 2/6/2025, by Rep. Martha Deuter

SYNOPSIS AS INTRODUCED:

215 ILCS 5/363

Amends the Illinois Insurance Code. Provides that an issuer of a Medicare supplement policy shall not deny coverage to an applicant who voluntarily switches from a Medicare Advantage plan to a Medicare plan under Parts A, B, or D, or any combination of those plans, so long as the application for a Medicare supplement policy is submitted within 30 calendar days after the first effective day of the new plan. Provides that when such an application for a Medicare supplement policy is submitted, the issuer of the Medicare supplement policy may not charge a higher cost than what is normally offered to applicants who have become newly eligible for Medicare, nor raise costs or deny coverage for a preexisting condition.

LRB104 11933 BAB 22026 b

1 AN ACT concerning regulation.

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

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

6 (215 ILCS 5/363)

7 (Text of Section before amendment by P.A. 103-747)

8 Sec. 363. Medicare supplement policies; minimum standards.

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

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

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

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

1 Medicare supplement policies or benefit plans.

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

4 (a) "Applicant" means:

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

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

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

13 (c) "Medicare supplement policy" means an individual
14 policy of accident and health insurance, as defined in
15 paragraph (a) of subsection (2) of Section 355a of this
16 Code, or a group policy or certificate delivered or issued
17 for delivery in this State by an insurer, fraternal
18 benefit society, voluntary health service plan, or health
19 maintenance organization, other than a policy issued
20 pursuant to a contract under Section 1876 of the federal
21 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
22 policy issued under a demonstration project specified in
23 42 U.S.C. Section 1395ss(g)(1), or any similar
24 organization, that is advertised, marketed, or designed
25 primarily as a supplement to reimbursements under Medicare
26 for the hospital, medical, or surgical expenses of persons

1 eligible for Medicare.

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

7 (e) "Medicare" means the Health Insurance for the Aged
8 Act, Title XVIII of the Social Security Amendments of
9 1965.

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

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

1 (5) A Medicare supplement policy or certificate may not
2 deny a claim for losses incurred more than 6 months from the
3 effective date of coverage for a preexisting condition. The
4 policy may not define a preexisting condition more
5 restrictively than a condition for which medical advice was
6 given or treatment was recommended by or received from a
7 physician within 6 months before the effective date of
8 coverage.

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

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

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

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

1 (iii) is insured by a Medicare Advantage plan that
2 includes a Health Maintenance Organization, a
3 Preferred Provider Organization, and a Private
4 Fee-For-Service or Medicare Select plan and the
5 applicant moves out of the plan's service area; the
6 insurer goes out of business, withdraws from the
7 market, or has its Medicare contract terminated; ~~or~~
8 the plan violates its contract provisions or is
9 misrepresented in its marketing; or

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

15 (a-5) not deny coverage if the applicant voluntarily
16 switches from a Medicare Advantage plan to a Medicare plan
17 under Part A, B, or D, or any combination of those plans,
18 so long as the application for a Medicare supplement
19 policy is submitted within 30 calendar days after the
20 first effective day of the new plan. When such an
21 application for a Medicare supplement policy is submitted,
22 the issuer of the Medicare supplement policy may not
23 charge a higher cost than what is normally offered to
24 applicants who have become newly eligible for Medicare,
25 nor raise costs or deny coverage for a preexisting
26 condition. As used in this paragraph (a-5), "preexisting

1 condition" has the meaning given to that term in Section
2 351A-5 of this Code;

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

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

14 (d) provide the rights granted by items (a) through
15 (d), for 6 months after June 1, 2008 (the effective date of
16 Public Act 95-436) ~~this amendatory Act of the 95th General~~
17 ~~Assembly~~, to any person who had enrolled for benefits
18 under Medicare Part B prior to Public Act 95-436 and this
19 ~~amendatory Act of the 95th General Assembly~~ who otherwise
20 would have been eligible for coverage under item (a).

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

23 (a) To establish specific standards for policy
24 provisions of Medicare policies and certificates. The
25 standards shall be in accordance with the requirements of
26 this Code. No requirement of this Code relating to minimum

1 required policy benefits, other than the minimum standards
2 contained in this Section and Section 363a, shall apply to
3 Medicare supplement policies and certificates. The
4 standards may cover, but are not limited to the following:

5 (A) Terms of renewability.

6 (B) Initial and subsequent terms of eligibility.

7 (C) Non-duplication of coverage.

8 (D) Probationary and elimination periods.

9 (E) Benefit limitations, exceptions and
10 reductions.

11 (F) Requirements for replacement.

12 (G) Recurrent conditions.

13 (H) Definition of terms.

14 (I) Requirements for issuing rebates or credits to
15 policyholders if the policy's loss ratio does not
16 comply with subsection (7) of Section 363a.

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

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

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

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

26 (N) Establishing standards for Medicare Select

1 policies.

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

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

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

16 (8) If an individual is at least 65 years of age but no
17 more than 75 years of age and has an existing Medicare
18 supplement policy, the individual is entitled to an annual
19 open enrollment period lasting 45 days, commencing with the
20 individual's birthday, and the individual may purchase any
21 Medicare supplement policy with the same issuer that offers
22 benefits equal to or lesser than those provided by the
23 previous coverage. During this open enrollment period, an
24 issuer of a Medicare supplement policy shall not deny or
25 condition the issuance or effectiveness of Medicare
26 supplemental coverage, nor discriminate in the pricing of

1 coverage, because of health status, claims experience, receipt
2 of health care, or a medical condition of the individual. An
3 issuer shall provide notice of this annual open enrollment
4 period for eligible Medicare supplement policyholders at the
5 time that the application is made for a Medicare supplement
6 policy or certificate. The notice shall be in a form that may
7 be prescribed by the Department.

8 (9) Without limiting an individual's eligibility under
9 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for
10 at least 63 days after the later of the applicant's loss of
11 benefits or the notice of termination of benefits, including a
12 notice of claim denial due to termination of benefits, under
13 the State's medical assistance program under Article V of the
14 Illinois Public Aid Code, an issuer shall not deny or
15 condition the issuance or effectiveness of any Medicare
16 supplement policy or certificate that is offered and is
17 available for issuance to new enrollees by the issuer; shall
18 not discriminate in the pricing of such a Medicare supplement
19 policy because of health status, claims experience, receipt of
20 health care, or medical condition; and shall not include a
21 policy provision that imposes an exclusion of benefits based
22 on a preexisting condition under such a Medicare supplement
23 policy if the individual:

24 (a) is enrolled for Medicare Part B;

25 (b) was enrolled in the State's medical assistance
26 program during the COVID-19 Public Health Emergency

1 described in Section 5-1.5 of the Illinois Public Aid
2 Code;

3 (c) was terminated or disenrolled from the State's
4 medical assistance program after the COVID-19 Public
5 Health Emergency and the later of the date of termination
6 of benefits or the date of the notice of termination,
7 including a notice of a claim denial due to termination,
8 occurred on, after, or no more than 63 days before the end
9 of either, as applicable:

10 (A) the individual's Medicare supplement open
11 enrollment period described in Department rules
12 implementing 42 U.S.C. 1395ss(s) (2) (A); or

13 (B) the 6-month period described in Section
14 363(6) (a) (i) of this Code; and

15 (d) submits evidence of the date of termination of
16 benefits or notice of termination under the State's
17 medical assistance program with the application for a
18 Medicare supplement policy or certificate.

19 (10) Each Medicare supplement policy and certificate
20 available from an insurer on and after June 16, 2023 (the
21 effective date of Public Act 103-102) ~~this amendatory Act of~~
22 ~~the 103rd General Assembly~~ shall be made available to all
23 applicants who qualify under subparagraph (i) of paragraph (a)
24 of subsection (6) or Department rules implementing 42 U.S.C.
25 1395ss(s) (2) (A) without regard to age or applicability of a
26 Medicare Part B late enrollment penalty.

1 (Source: P.A. 102-142, eff. 1-1-22; 103-102, eff. 6-16-23;
2 revised 10-24-24.)

3 (Text of Section after amendment by P.A. 103-747)

4 Sec. 363. Medicare supplement policies; minimum standards.

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

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

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

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

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

23 (a) "Applicant" means:

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

1 benefits, and

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

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

7 (c) "Medicare supplement policy" means an individual
8 policy of accident and health insurance, as defined in
9 paragraph (a) of subsection (2) of Section 355a of this
10 Code, or a group policy or certificate delivered or issued
11 for delivery in this State by an insurer, fraternal
12 benefit society, voluntary health service plan, or health
13 maintenance organization, other than a policy issued
14 pursuant to a contract under Section 1876 of the federal
15 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
16 policy issued under a demonstration project specified in
17 42 U.S.C. Section 1395ss(g)(1), or any similar
18 organization, that is advertised, marketed, or designed
19 primarily as a supplement to reimbursements under Medicare
20 for the hospital, medical, or surgical expenses of persons
21 eligible for Medicare.

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

1 (e) "Medicare" means the Health Insurance for the Aged
2 Act, Title XVIII of the Social Security Amendments of
3 1965.

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

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

21 (5) A Medicare supplement policy or certificate may not
22 deny a claim for losses incurred more than 6 months from the
23 effective date of coverage for a preexisting condition. The
24 policy may not define a preexisting condition more
25 restrictively than a condition for which medical advice was
26 given or treatment was recommended by or received from a

1 physician within 6 months before the effective date of
2 coverage.

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

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

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

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

21 (iii) is insured by a Medicare Advantage plan that
22 includes a Health Maintenance Organization, a
23 Preferred Provider Organization, and a Private
24 Fee-For-Service or Medicare Select plan and the
25 applicant moves out of the plan's service area; the
26 insurer goes out of business, withdraws from the

1 market, or has its Medicare contract terminated; ~~or~~
2 the plan violates its contract provisions or is
3 misrepresented in its marketing; or

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

9 (a-5) not deny coverage if the applicant voluntarily
10 switches from a Medicare Advantage plan to a Medicare plan
11 under Part A, B, or D, or any combination of those plans,
12 so long as the application for a Medicare supplement
13 policy is submitted within 30 calendar days after the
14 first effective day of the new plan. When such an
15 application for a Medicare supplement policy is submitted,
16 the issuer of the Medicare supplement policy may not
17 charge a higher cost than what is normally offered to
18 applicants who have become newly eligible for Medicare,
19 nor raise costs or deny coverage for a preexisting
20 condition. As used in this paragraph (a-5), "preexisting
21 condition" has the meaning given to that term in Section
22 351A-5 of this Code;

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

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

8 (d) provide the rights granted by items (a) through
9 (d), for 6 months after June 1, 2008 (the effective date of
10 Public Act 95-436) ~~this amendatory Act of the 95th General~~
11 ~~Assembly~~, to any person who had enrolled for benefits
12 under Medicare Part B prior to Public Act 95-436 and ~~this~~
13 ~~amendatory Act of the 95th General Assembly~~ who otherwise
14 would have been eligible for coverage under item (a).

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

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

25 (A) Terms of renewability.

26 (B) Initial and subsequent terms of eligibility.

1 (C) Non-duplication of coverage.

2 (D) Probationary and elimination periods.

3 (E) Benefit limitations, exceptions and
4 reductions.

5 (F) Requirements for replacement.

6 (G) Recurrent conditions.

7 (H) Definition of terms.

8 (I) Requirements for issuing rebates or credits to
9 policyholders if the policy's loss ratio does not
10 comply with subsection (7) of Section 363a.

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

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

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

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

20 (N) Establishing standards for Medicare Select
21 policies.

22 (O) Prohibited policy provisions not otherwise
23 specifically authorized by statute that, in the
24 opinion of the Director, are unjust, unfair, or
25 unfairly discriminatory to any person insured or
26 proposed for coverage under a Medicare ~~medicare~~

1 supplement policy or certificate.

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

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

10 (8) If an individual is at least 65 years of age but no
11 more than 75 years of age and has an existing Medicare
12 supplement policy, the individual is entitled to an annual
13 open enrollment period lasting 45 days, commencing with the
14 individual's birthday, and the individual may purchase any
15 Medicare supplement policy with the same issuer or any
16 affiliate authorized to transact business in this State that
17 offers benefits equal to or lesser than those provided by the
18 previous coverage. During this open enrollment period, an
19 issuer of a Medicare supplement policy shall not deny or
20 condition the issuance or effectiveness of Medicare
21 supplemental coverage, nor discriminate in the pricing of
22 coverage, because of health status, claims experience, receipt
23 of health care, or a medical condition of the individual. An
24 issuer shall provide notice of this annual open enrollment
25 period for eligible Medicare supplement policyholders at the
26 time that the application is made for a Medicare supplement

1 policy or certificate. The notice shall be in a form that may
2 be prescribed by the Department.

3 (9) Without limiting an individual's eligibility under
4 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for
5 at least 63 days after the later of the applicant's loss of
6 benefits or the notice of termination of benefits, including a
7 notice of claim denial due to termination of benefits, under
8 the State's medical assistance program under Article V of the
9 Illinois Public Aid Code, an issuer shall not deny or
10 condition the issuance or effectiveness of any Medicare
11 supplement policy or certificate that is offered and is
12 available for issuance to new enrollees by the issuer; shall
13 not discriminate in the pricing of such a Medicare supplement
14 policy because of health status, claims experience, receipt of
15 health care, or medical condition; and shall not include a
16 policy provision that imposes an exclusion of benefits based
17 on a preexisting condition under such a Medicare supplement
18 policy if the individual:

19 (a) is enrolled for Medicare Part B;

20 (b) was enrolled in the State's medical assistance
21 program during the COVID-19 Public Health Emergency
22 described in Section 5-1.5 of the Illinois Public Aid
23 Code;

24 (c) was terminated or disenrolled from the State's
25 medical assistance program after the COVID-19 Public
26 Health Emergency and the later of the date of termination

1 of benefits or the date of the notice of termination,
2 including a notice of a claim denial due to termination,
3 occurred on, after, or no more than 63 days before the end
4 of either, as applicable:

5 (A) the individual's Medicare supplement open
6 enrollment period described in Department rules
7 implementing 42 U.S.C. 1395ss(s) (2) (A); or

8 (B) the 6-month period described in Section
9 363(6) (a) (i) of this Code; and

10 (d) submits evidence of the date of termination of
11 benefits or notice of termination under the State's
12 medical assistance program with the application for a
13 Medicare supplement policy or certificate.

14 (10) Each Medicare supplement policy and certificate
15 available from an insurer on and after June 16, 2023 (the
16 effective date of Public Act 103-102) ~~this amendatory Act of~~
17 ~~the 103rd General Assembly~~ shall be made available to all
18 applicants who qualify under subparagraph (i) of paragraph (a)
19 of subsection (6) or Department rules implementing 42 U.S.C.
20 1395ss(s) (2) (A) without regard to age or applicability of a
21 Medicare Part B late enrollment penalty.

22 (Source: P.A. 102-142, eff. 1-1-22; 103-102, eff. 6-16-23;
23 103-747, eff. 1-1-26; revised 10-24-24.)

24 Section 95. No acceleration or delay. Where this Act makes
25 changes in a statute that is represented in this Act by text

1 that is not yet or no longer in effect (for example, a Section
2 represented by multiple versions), the use of that text does
3 not accelerate or delay the taking effect of (i) the changes
4 made by this Act or (ii) provisions derived from any other
5 Public Act.