

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) (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 on
12 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.

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

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

3 (a) "Applicant" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (7) ~~(6)~~ The Director shall issue reasonable rules and
6 regulations for the following purposes:

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

15 (A) Terms of renewability.

16 (B) Initial and subsequent terms of eligibility.

17 (C) Non-duplication of coverage.

18 (D) Probationary and elimination periods.

19 (E) Benefit limitations, exceptions and
20 reductions.

21 (F) Requirements for replacement.

22 (G) Recurrent conditions.

23 (H) Definition of terms.

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

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

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

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

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

10 (N) Establishing standards for Medicare Select
11 policies.

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

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

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

26 (Source: P.A. 88-313; 89-484, eff. 6-21-96.)