



## 103RD GENERAL ASSEMBLY

### State of Illinois

2023 and 2024

SB2910

Introduced 1/26/2024, by Sen. Laura Fine

#### SYNOPSIS AS INTRODUCED:

215 ILCS 5/363

from Ch. 73, par. 975

Amends the Illinois Insurance Code. In provisions concerning Medicare supplement policy minimum standards, provides that if an individual is at least 65 years of age but no more than 75 years of age and has an existing Medicare supplement policy, then the individual is entitled to an annual open enrollment period lasting 45 days, commencing with the individual's birthday, and the individual may purchase any Medicare supplement policy with the same issuer or any affiliate authorized to transact business in the State (instead of only the same issuer) that offers benefits equal to or lesser than those provided by the previous coverage.

LRB103 36030 RPS 66117 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) (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.

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  
17 benefit 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  
22 42 U.S.C. Section 1395ss(g)(1), or any similar  
23 organization, that is advertised, marketed, or designed  
24 primarily as a supplement to reimbursements under Medicare  
25 for the 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  
8           1965.

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

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

26          (5) A Medicare supplement policy or certificate may not

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

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

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

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

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

26 (iii) is insured by a Medicare Advantage plan that

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

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

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

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

25 (d) provide the rights granted by items (a) through  
26 (d), for 6 months after the effective date of this

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

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

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

16                (A) Terms of renewability.

17                (B) Initial and subsequent terms of eligibility.

18                (C) Non-duplication of coverage.

19                (D) Probationary and elimination periods.

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

22                (F) Requirements for replacement.

23                (G) Recurrent conditions.

24                (H) Definition of terms.

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

1 comply with subsection (7) of Section 363a.

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

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

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

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

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

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

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

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



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

20           (9) Without limiting an individual's eligibility under  
21 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for  
22 at least 63 days after the later of the applicant's loss of  
23 benefits or the notice of termination of benefits, including a  
24 notice of claim denial due to termination of benefits, under  
25 the State's medical assistance program under Article V of the  
26 Illinois Public Aid Code, an issuer shall not deny or

1 condition the issuance or effectiveness of any Medicare  
2 supplement policy or certificate that is offered and is  
3 available for issuance to new enrollees by the issuer; shall  
4 not discriminate in the pricing of such a Medicare supplement  
5 policy because of health status, claims experience, receipt of  
6 health care, or medical condition; and shall not include a  
7 policy provision that imposes an exclusion of benefits based  
8 on a preexisting condition under such a Medicare supplement  
9 policy if the individual:

10 (a) is enrolled for Medicare Part B;

11 (b) was enrolled in the State's medical assistance  
12 program during the COVID-19 Public Health Emergency  
13 described in Section 5-1.5 of the Illinois Public Aid  
14 Code;

15 (c) was terminated or disenrolled from the State's  
16 medical assistance program after the COVID-19 Public  
17 Health Emergency and the later of the date of termination  
18 of benefits or the date of the notice of termination,  
19 including a notice of a claim denial due to termination,  
20 occurred on, after, or no more than 63 days before the end  
21 of either, as applicable:

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

25 (B) the 6-month period described in Section  
26 363(6) (a) (i) of this Code; and

1           (d) submits evidence of the date of termination of  
2           benefits or notice of termination under the State's  
3           medical assistance program with the application for a  
4           Medicare supplement policy or certificate.

5           (10) Each Medicare supplement policy and certificate  
6           available from an insurer on and after the effective date of  
7           this amendatory Act of the 103rd General Assembly shall be  
8           made available to all applicants who qualify under  
9           subparagraph (i) of paragraph (a) of subsection (6) or  
10          Department rules implementing 42 U.S.C. 1395ss(s)(2)(A)  
11          without regard to age or applicability of a Medicare Part B  
12          late enrollment penalty.

13          (Source: P.A. 102-142, eff. 1-1-22; 103-102, eff. 6-16-23.)