AN ACT concerning insurance.

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 Sections 351A-1, 351A-4, 351A-7, and 351A-8 and adding Sections 351A-9.2 and 351A-9.3 as follows:

(215 ILCS 5/351A-1) (from Ch. 73, par. 963A-1)

Sec. 351A-1. Definitions. Unless the context requires otherwise, in this Article:

(a) "Long-term care insurance" means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. <u>The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts.</u> Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare

supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.

(b) "Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(c) "Certificate" means, for the purposes of this Article, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

(d) "Director" means the Director of Insurance of this State.

(e) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to one of the following:

(1) One or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(2) Any professional, trade or occupational association for its members or former or retired members,

or combination thereof, if such association:

(A) is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) has been maintained in good faith for purposes other than obtaining insurance.

(3) An association or a trust or the trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least one year, and have a constitution and by-laws which provide that:

(A) the association or associations hold regular meetings not less than annually to further the purposes of the members;

(B) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) the members have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in paragraph (1), (2) or (3) of this subsection (e), subject to a

finding by the Director that:

(A) the issuance of the group policy is not contrary to the best interest of the public;

(B) the issuance of the group policy would result in economies of acquisition or administration; and

(C) the benefits are reasonable in relation to the premiums charged.

(f) "Policy" means, for the purposes of this Article, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

(g) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII

of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(3) The contract is guaranteed renewable within the meaning of Section 7702(B)(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (5).

(5) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(6) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and 7702B(e) of the Internal Revenue Code of 1986, as amended.

(Source: P.A. 86-384.)

(215 ILCS 5/351A-4) (from Ch. 73, par. 963A-4)

Sec. 351A-4. Limitation. No long-term care insurance

policy may:

(1) Be cancelled, nonrenewed or otherwise terminated on grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form ~~within the same company~~, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(Source: P.A. 85-1172; 85-1174; 85-1440.)

(215 ILCS 5/351A-7) (from Ch. 73, par. 963A-7)

Sec. 351A-7. Right to return.

(a) An individual long-term care insurance policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded directly to him or her if, after examination of the policy, the policyholder is not satisfied for any reason. Long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(b) A person insured under a long-term care insurance policy or certificate issued pursuant to a direct response solicitation 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 if, after examination, the insured person is not satisfied for any

reason. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy or certificate attached thereto stating in substance that the insured person shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. <u>This subsection also applies to denials of applications, and any refund must be made within 30 days of the return or denial.</u>

(Source: P.A. 85-1440; 86-384.)

(215 ILCS 5/351A-8) (from Ch. 73, par. 963A-8)

Sec. 351A-8. Outline of coverage.

(a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(1) The Director shall prescribe a standard format including style, arrangement and overall appearance and the content of an outline of coverage.

(2) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(b) The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the principal exclusions, reductions and limitations contained in the policy.

(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contain governing contractual provisions.

(5) A description of the terms under which the policy or certificate may be returned and premium refunded.

(6) A brief description of the relationship of cost of care and benefits.

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

(Source: P.A. 85-1440; 86-384.)

(215 ILCS 5/351A-9.2 new)

Sec. 351A-9.2. Delivery of policy. If an applicant for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

(215 ILCS 5/351A-9.3 new)

Sec. 351A-9.3. Claim denial; explanation. If a claim under a long-term care insurance contract is denied, the issuer, within 60 days after receipt of a written request by a policyholder or certificate holder or a policyholder's or

certificate holder's representative shall:

(1) provide a written explanation of the reasons for the denial; and

(2) make available all information directly related to the denial.

Section 99. Effective date. This Act takes effect upon becoming law.