

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1652.001. DEFINITIONS. In this chapter:

(1) "Applicant" means:

(A) an individual who seeks to contract for insurance or other health benefits under an individual Medicare supplement benefit plan; or

(B) the proposed certificate holder of a group Medicare supplement benefit plan.

(2) "Approved regulatory program" means a state regulatory program that complies with the requirements of Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(3) "Medicare" means the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a) "Medicare supplement benefit plan" means a group or individual policy of accident and health insurance, a subscriber contract of a group hospital service corporation operating under Chapter 842, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of an individual eligible for Medicare.

(b) A policy, contract, subscriber contract, or evidence of coverage is not considered to be a Medicare supplement benefit plan if it is:

(1) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or

more employers or labor organizations, or a combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations;

(2) a policy or health care benefit plan, including a policy or contract of group insurance, a group contract of a group hospital service corporation operating under Chapter 842, or a group evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is not marketed or held to be a Medicare supplement benefit plan; or

(3) an individual or group evidence of coverage issued in accordance with a contract under Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm), by a health maintenance organization operating under Chapter 843.

(c) The commissioner by rule may modify the definition of "Medicare supplement benefit plan" provided by Subsection (a) to the extent necessary for this state to qualify as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter applies to an individual or group Medicare supplement benefit plan delivered or issued for delivery in this state and, regardless of the place where the plan was delivered or issued for delivery, a certificate that was issued under a group Medicare supplement benefit plan and delivered or issued for delivery in this state, if the plan or certificate is issued by:

(1) a capital stock insurance company, including a life, health and accident, and general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment company, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association of any kind, including an association subject to Section 887.102;

(5) a mutual insurance company other than a life insurance company;

(6) a mutual or natural premium life or casualty

insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842;

(11) a stipulated premium company;

(12) another insurer that by law is required to be authorized by the department; or

(13) a health maintenance organization operating under Chapter 843, to the extent required by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter may not be construed to enlarge the powers of an entity described by Section 1652.003.

(b) This chapter controls to the extent of any conflict with another provision of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In addition to other rules required or authorized by this chapter, the commissioner shall adopt reasonable rules necessary and proper to carry out this chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER B. BENEFITS

Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance

with:

- (1) applicable laws of this state, including Chapters 842 and 1201;
- (2) applicable federal law, rules, regulations, and standards; and
- (3) any model rules and regulations required by federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(b) The standards may include provisions relating to:

- (1) terms of renewability;
- (2) initial and subsequent conditions of eligibility;
- (3) nonduplication of coverage;
- (4) probationary periods;
- (5) benefit limitations, exceptions, and reductions;
- (6) elimination periods;
- (7) requirements for replacement;
- (8) recurrent conditions;
- (9) definitions of terms; and
- (10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

- (1) are not otherwise specifically authorized by statute; and
- (2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must

include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare supplement benefit plan or certificate in force in this state may not contain benefits that duplicate benefits provided by Medicare. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.054. BASIC PLAN. An entity described by Section 1652.003 that offers for sale in this state a Medicare supplement benefit plan must offer a basic Medicare supplement benefit plan that:

(1) provides only those benefits common to all Medicare supplement benefit plans; and

(2) meets but does not exceed the minimum standards of benefits for Medicare supplement benefit plans adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the basic Medicare supplement benefit plan described by Section 1652.054, an entity may offer additional Medicare supplement benefit plans for sale in this state.

(b) The combination of benefits provided by an additional plan must conform to one of the benefit packages adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(c) The commissioner by rule shall provide for the approval of new or innovative benefits that may be provided in a plan other than the basic plan and that otherwise comply with this subchapter. The benefits must:

(1) be offered in a manner consistent with the goal of Medicare supplement benefit plan simplification; and

(2) meet the requirements prescribed by Section 1882,

Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement benefit plan must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(c) The coverage for the annual screening may not be less favorable than coverage for other radiological examinations and must be subject to the same dollar limits, deductibles, and coinsurance factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity that delivers or issues for delivery in this state a Medicare supplement benefit plan or certificate that replaces a Medicare supplement benefit plan or certificate shall give credit for the satisfaction or partial satisfaction of any waiting period, elimination period, or probationary period for a preexisting condition that has been satisfied under the plan being replaced.

(b) A replacement plan that clearly provides a new or additional benefit may include appropriate and clearly stated periods as a condition for payment of the new or additional benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A Medicare supplement benefit plan may not contain a provision that excludes coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A Medicare supplement benefit plan 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 six months before the effective date of coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER C. LOSS RATIO STANDARDS

Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare supplement benefit plan must return to a plan holder benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans. The standards must be established:

(1) on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage;

(2) in accordance with accepted actuarial principles and practices; and

(3) to the extent necessary for the state to obtain or retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each entity providing Medicare supplement benefit plans in this state shall file with the department the entity's rates, rating schedule, and supporting documentation demonstrating that:

(1) the entity is complying with the applicable loss ratio standards of this state; and

(2) the actual and expected losses in relation to premiums comply with the requirements of this subchapter and the rules adopted by the commissioner.

(b) The documentation required by Subsection (a) must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue.

(c) The commissioner may adopt rules relating to filing

requirements for rates, rating schedules, and loss ratios.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The commissioner by rule shall provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

(b) The rules must comply with federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on which a Medicare benefit change required by federal law takes effect, each entity providing in this state a Medicare supplement benefit plan existing on the effective date of the change shall file with the commissioner, in accordance with Chapter 1701:

(1) each appropriate premium adjustment necessary to produce the loss ratios originally anticipated for the applicable plan, accompanied by any supporting documents necessary to justify the adjustment; and

(2) each appropriate rider, endorsement, or plan form necessary to modify the coverage so as to eliminate benefit duplications with Medicare.

(b) A rider, endorsement, or plan form required by Subsection (a) must provide a clear description of the Medicare supplement benefits provided by the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program, the department shall comply with federal requirements relating to periodic reporting of loss ratio information to the secretary of health and human services, based on a uniform methodology, as authorized by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules adopted under Sections 1652.152, 1652.153, and 1652.154 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in this state unless an outline of coverage that complies with this section is delivered to the applicant when the applicant applies for the coverage.

(b) The commissioner by rule shall prescribe the format and content of the outline of coverage required by Subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The commissioner by rule may prescribe a standard form and the contents of an informational brochure intended to improve the ability of an individual eligible for Medicare to understand Medicare and to select the most appropriate Medicare supplement coverage.

(b) Except as provided by Subsection (c), the commissioner by rule may require that the informational brochure be provided to an individual eligible for Medicare concurrently with delivery of the outline of coverage.

(c) If the plan is a direct response Medicare supplement benefit plan, the commissioner by rule may require that the informational brochure be provided on request to an individual eligible for Medicare at any time not later than the time the plan is delivered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE.

(a) The commissioner may adopt reasonable rules for captions or notice requirements for each accident and health insurance policy, subscriber contract, or evidence of coverage sold to an individual eligible for Medicare that are determined to be in the public interest and designed to inform the individual that a particular coverage is not a Medicare supplement benefit plan. This subsection does not apply to:

- (1) a Medicare supplement benefit plan;
- (2) a disability income policy;
- (3) a basic, catastrophic, or major medical expense policy;
- (4) a single premium nonrenewable policy; or
- (5) another policy, contract, or subscriber contract described by Section [1652.002\(b\)\(1\)](#) or (2).

(b) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information relating to replacing an accident and health insurance policy, a subscriber contract, or a certificate by an individual eligible for Medicare.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If an applicant is not satisfied for any reason after examining a Medicare supplement benefit plan document or certificate, the applicant is entitled to receive a refund of the premium if the applicant returns the document or certificate not later than the 30th day after the date it is delivered.

(b) The entity issuing the plan or certificate shall refund the premium directly to the applicant in a timely manner.

(c) A Medicare supplement benefit plan or certificate must have a notice stating the substance prescribed by Subsection (a) prominently printed on the first page of or attached to the plan or certificate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The commissioner shall adopt reasonable rules to require each entity described by Section 1652.003 to file with the department a copy of any advertisement relating to Medicare supplement benefit plans that the entity intends to use in this state. The rules must require that the entity file the copy not later than the 60th day before the date of intended use.

(b) At the expiration of the 60-day period provided by Subsection (a), an advertisement filed in accordance with that subsection is considered acceptable, unless before the end of that 60-day period the department notifies the entity of the advertisement's nonacceptance.

(c) An entity may not use an advertisement for Medicare supplement benefit plans that does not comply with state law, including department rules and Section 541.084.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. 2251), Sec. 3, eff. September 1, 2007.

SUBCHAPTER E. AGENTS

Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An entity that offers a Medicare supplement benefit plan for sale in this state shall provide to each agent authorized to sell that plan information relating to:

- (1) Medicare;
- (2) the Medicare supplement benefit plans offered by that entity; and
- (3) the agent's ethical obligations to clients.

(b) The commissioner by rule may prescribe the information that must be provided under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare

supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER F. OUTPATIENT PRESCRIPTION DRUGS

Sec. 1652.251. OUTPATIENT PRESCRIPTION DRUG BENEFIT PLANS.

(a) An entity described by Section 1652.003 that issues a Medicare supplement benefit plan in this state may offer a group or individual policyholder:

(1) an outpatient prescription drug benefit plan authorized under 42 U.S.C. Section 1395ss; or

(2) a new or innovative outpatient prescription drug benefit plan filed with and approved by the commissioner under Section 1652.055.

(b) The commissioner shall approve or disapprove an outpatient drug benefit plan described by Subsection (a) that is filed for approval under Section 1652.055 not later than the 60th day after the date the entity files the plan with the department. A drug benefit plan that has not been approved or disapproved by the commissioner before the 61st day after the date the plan is filed with the department is considered approved on that day.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.075(a), eff. September 1, 2005.

Sec. 1652.252. PRESCRIPTION DRUG DISCOUNT PROGRAMS. (a) In this section, "prescription drug discount program" means any program that entitles a participant to purchase prescription drugs or other medical supplies and services from vendors at a discount under an agreement made with a participating pharmacy.

(b) An entity described by Section 1652.003 may offer participation in a prescription drug discount program in connection with the solicitation of an application for issuance of a Medicare

supplement benefit plan.

(c) An offer of participation in a prescription drug discount program described by this section is not a violation of Chapter [541](#) or any other law prohibiting the offer of rebates in the solicitation of insurance policies.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.075(a), eff. September 1, 2005.