# Attachment A

# House and Senate Bills Relating to

# Life, Accident, or Health Insurers; Health Maintenance Organizations; Independent Review Organizations; Insurance Agents; Multiple Employer Welfare Arrangements; Third Party Administrators; Utilization Review Agents; Viatical and Life Settlement Providers, Provider Representatives, and Brokers; Workers’ Compensation Healthcare Networks; and/or Discount Health Care Program Operators.\*

## House Bills

HB0001 Study, Mandated Health Benefits -- HB0001, Rider 19, requires TDI to analyze the cost to the state of maintaining each of the health benefits if required by Texas state statute and if the state will be responsible for paying for such health benefits in a health insurance exchange operating in the state. TDI is required to submit a report to the Governor and the Legislative Budget Board not later than the earlier of 90 days after federal rules are finalized or December 31, 2012. The report must include any rationale for and future costs to the state of maintaining any given mandated health benefits.

Effective September 1, 2011.

[HB0300](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB00300F.htm) Privacy of Health Information – HB0300 requires a covered entity under the Texas Insurance Code Chapter 602 to comply with Health and Safety Code, Chapter 181, Subchapter D, which prohibits the disclosure of protected health information to any other person in exchange for direct or indirect remuneration, with exceptions. It sets forth administrative, civil, and criminal penalties for disclosure or sale of protected health information or other violations of Health and Safety Code Chapter 181 regarding Medical Records Privacy. The bill also requires a training program be established by a covered entity for its employees regarding the state and federal laws concerning protected health information. It also contains provisions for consumer access to electronic health records, if used by a health care provider. If the protected health information is subject to electronic disclosure, then notice and authorization is required. The bill provides three methods of posting written notice so affected individuals are informed. The bill also requires a covered entity to comply with the standards for electronic sharing that are adopted under Health and Safety Code Section 182.108, which is required to be adopted by January 1, 2013.

Effective September 1, 2012; applies only to conduct or offenses that occur on or after September 1, 2012.

[HB0438](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB00438F.htm) Coverage of Orally Administered Anticancer Medications --HB0438 requires specifically enumerated health benefit plans that provide coverage for cancer treatment to provide coverage for prescribed orally administered anticancer medication on the same basis it provides coverage for intravenously administered anticancer medication. A health benefit plan may require prior authorization for the anticancer medication. The bill restricts health benefit plans from re-classifying anticancer medications or increasing out-of-pocket expenses unless applied to the majority of comparable medical or pharmaceutical benefits under the plan. It does not prohibit increasing cost-sharing for all benefits, including anticancer treatments.

Effective September 1, 2011; applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012.

[HB1032](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01032F.htm) Annuity Rescission Periods -- HB1032 creates a free look period for purchasers of fixed, variable, or modified guaranteed annuities of at least twenty days after the delivery of the contract. A fixed annuity must allow the purchaser to rescind the contract and receive an unconditional refund of the premiums paid, including any contract fees or charges. A variable or modified guaranteed annuity contract must allow the purchaser to rescind the contract and receive an unconditional refund of the cash surrender value plus any fees or charges. A variable or modified guaranteed annuity contract is not required to provide a rescission period if the prospective owner is an accredited investor.

Effective September 1, 2011; applies only to an annuity contract delivered or issued for delivery on or after January 1, 2012.

[HB1405](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01405F.htm) Drug Formulary Changes -- HB1405 extends regulations on the use of drug formularies to include individual plans and small employer groups. The bill provides an exception for the Children’s Health Insurance Program (CHIP) and Medicaid. The bill also creates a 60-day notice requirement for modifications of drug coverage under certain conditions to be sent to all plan sponsors and enrollees and to TDI. The bill specifies the types of modifications that require the notifications and allows the health benefit plan to offer an enrollee the option of receiving notifications by e-mail.

Effective September 1, 2011; applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2012.

[HB1674](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01674F.htm) Child Support Liens -- HB1674 provides that after a child support lien notice has been filed, an assignment of benefits or rights under an insurance policy or annuity contract by an insured, owner, or annuitant continues to be subject to the child support lien after the date of assignment. The bill makes proceeds of a life insurance policy or annuity contract, including proceeds from the sale or assignment of same, subject to a child support lien. The bill requires a licensing authority, if notified by a child support agency, to refuse to accept an application for issuance or renewal of a license for applicants who are six months or more in arrears for child support. It establishes timelines and procedures for filing notice of levy on a financial institution account of a deceased obligor, who was the sole owner of the account, and how a person may contest the levy.

Effective September 1, 2011; applies to an assignment made on or after September 1, 2011.

[HB1720](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01720F.htm) Provider Accountability Under Medicaid or CHIP -- HB1720 requires a provider (including a nurse practitioner or physician assistant) under the Medicaid or CHIP program who provides a referral or orders health care services to include the supervising provider's name and national provider identification number on any claim for reimbursement that would be based on the referral or order. If a managed care organization’s special investigative unit or entity discovers fraud or abuse in the Medicaid or CHIP program, it must notify the Health and Human Services Commission’s (HHSC) Office of Inspector General and the Office of the Attorney General and begin payment recovery efforts. The bill establishes conditions when the special investigative unit cannot seek recovery and requires the HHSC to adopt rules for implementation. It also prohibits a person from participating in the CHIP program as a health care provider for a reasonable period if he/she fails to repay overpayments or if he/she is affiliated with a provider who has been suspended or prohibited from participating in the program.

Effective September 1, 2011.

[HB1772](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01772F.htm) Exclusive Provider Benefit Plans (EPBP) -- HB1772 permits insurers to offer EPBPs. It requires insurers offering these plans to establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice. These plans may exclude benefits, other than for emergency care, provided by a provider who is not a preferred provider. The bill permits EPBPs to fall within the definition of point-of-service plans, and essentially makes the same requirements of law that apply to preferred provider benefit plans apply to EPBPs (unless the commissioner determines otherwise). The bill requires insurers to include notice to current or prospective insureds that the benefit plan includes limited coverage for services provided by a non-preferred provider and further requires use of the acronym "EPO" or the phrase "Exclusive Provider Organization" on the plan’s identification card in a location of the insurer's choice. The bill allows the commissioner to examine and collect a fee from an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer.

Effective September 1, 2011; applies only to an EPBP that is delivered, issued for delivery, or renewed on or after January 1, 2012.

[HB1951](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB01951F.htm) Adjuster Advisory Board -- HB1951 creates a 9-member adjuster advisory board designed to advise the commissioner on matters related to the licensing, testing, and continuing education of licensed adjusters; claims handling, catastrophic loss preparedness, ethical guidelines, and other professionally relevant issues; and any other matter the commissioner submits to the advisory board for a recommendation.

Advisory Committees -- HB1951 repeals the statutory basis for several advisory boards, committees, and councils, including the consumer assistance program for health maintenance organizations (HMOs), the TexLink to Health Coverage Program Task Force, the HMO Solvency Surveillance Committee, the Technical Advisory Committee on Claims Processing, the Technical Advisory Committee on Electronic Data Exchange, advisory boards regarding agent continuing education and examination, and the utilization review agents advisory committee. The bill requires the commissioner to adopt rules to periodically evaluate an advisory committee to assess its continued necessity and rules to govern an advisory committee’s purpose/responsibility, size, qualifications, appointment procedures, terms of service, training requirements, and duration.

HMO Assessments -- HB1951 permits the assessment of HMOs to fund the commissioner's expenses associated in connection with an HMO in rehabilitation, liquidation, supervision, conservatorship, or seizure.

Limitations on Vision Contracting -- HB1951 prohibits the conditioning of a therapeutic optometrist’s or ophthalmologist’s inclusion in one or more of a managed care plan’s medical panels on the therapeutic optometrist’s or ophthalmologist’s inclusion in or acceptance of the terms of payment under or for a particular vision panel in which the therapeutic optometrist or ophthalmologist does not wish to be included.

Encouragement of Electronic Transactions -- HB1951 authorizes a regulated entity to conduct business electronically to the same extent as the entity is otherwise authorized to conduct business if each party agrees in advance to conduct the business electronically. The bill requires the commissioner to adopt rules that include minimum standards for the entity's electronic conduct of business with other regulated entities and consumers.

Expansion of TDI’s Duties --HB1951 expands TDI’s duties to include protecting and ensuring the fair treatment of consumers and ensuring fair competition in the insurance industry.

Individual Health Coverage for Children -- HB1951 allows the commissioner to adopt rules on an emergency basis in order to increase the availability of health insurance for children under the age of 19, which can include the establishment of open enrollment periods and qualifying events as exceptions to the open enrollment period.

Negotiated Rulemaking and Alternative Dispute Resolution -- HB1951 requires the commissioner to develop a policy to encourage negotiated rulemaking procedures and appropriate alternative dispute resolution procedures that conform, to the extent possible, to model guidelines issued by the State Office of Administrative Hearings (SOAH) for state agencies.

Health Insurance Rate Increase Notices – HB1951 requires that at least a 60-day advance written notice of a premium rate increase be given to the insured/enrollee under an individual accident and health policy or health maintenance organization evidence of coverage and to a small employer under a small employer health benefit plan. The notice must include the dollar amount of the premium at the time of notice, the dollar amount of the premium after the rate increase, the percentage of change between the premium rate at the time of the notice and the new increased rate, the effective date of the increase, contact information for TDI, information concerning filing complaints, contact information for the Texas Consumer Health Assistance Program, and the addresses for obtaining additional information regarding rate increase justifications.

Effective September 1, 2011; applies only to an insurance policy, contract, or evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 2012 except as otherwise provided.

[HB2069](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02069F.htm) Authority of Pharmacists to Accelerate Refills -- HB2069 authorizes a pharmacist to dispense up to a 90-day supply of dangerous drugs, pursuant to a valid prescription that specifies a lesser amount followed by refills of that amount, and accelerate refills upon certain conditions. Those conditions include that the total quantity of drugs dispensed must not exceed the total quantity authorized by the prescriber on the original prescription, including refills; the patient must consent to the dispensing of up to a 90-day supply and the physician must be notified electronically or by telephone; and the physician has not specified on the prescription that dispensing the prescription in an initial amount followed by periodic refills is medically necessary. Additionally, the dangerous drug must not be a psychotropic drug, and the patient must be at least 18 years of age.

Effective September 1, 2011.

[HB2098](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02098F.htm) Business Structures of Providers -- HB2098 permits physicians and physicians' assistants to form a corporation, partnership, professional association, or professional limited liability company to perform a professional service that falls within the scope of practice of those practitioners under the Business Organizations Code or a jointly owned entity under the Occupations Code. Organizers must be physicians and ensure that a physician manages and controls the entity, as well as performs professional services that fall within the scope of practice. Ownership interest of physicians' assistants is limited to a minority share.

Effective June 17, 2011.

[HB2154](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02154F.htm) Continuing Education for Agents -- HB2154 changes the continuing education requirement for agents selling annuities from four hours of annuity-related continuing education annually to eight hours of annuity-related continuing education biennially.

Effective September 1, 2011.

[HB2172](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02172F.htm) Eligible Children Under Group Life Insurance Policies --HB2172 expands coverage eligibility for certain children under group life insurance policies. The bill eliminates the requirement that eligible children be unmarried and younger than 25 years of age. It permits the coverage to extend to an age older than 25 that is stated in the policy. It also eliminates age and marital status eligibility requirements for natural or adopted grandchildren in the same manner, and removes the requirement that such grandchildren be dependents of the insured for federal income tax purposes.

Effective September 1, 2011; applies only to an insurance policy that is delivered, issued for delivery, renewed, or amended on or after January 1, 2012.

[HB2277](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02277F.htm) Annuity Waivers of Surrender Charges -- HB2277 excludes from the rebating provision the waiver of surrender charges for an annuity contract that is replaced by an annuity offered by an affiliate of the original issuer. It requires that the contract holder be given credit for the time that the previous contract was held when determining surrender charges.

Life Settlements -- HB2277 repeals the current viatical and life settlement chapter of the Texas Insurance Code and creates a new chapter, which combines both types of contracts under the label of life settlements. The bill prohibits the settlement of a life insurance policy in the first two years after issuance, with exceptions. The bill also provides consumer protections in the purchase of life settlement contracts and provides for penalties. The bill contains requirements for antifraud plans and reporting of fraud. It authorizes TDI to investigate suspected fraudulent life settlement acts and persons engaged in the business of life settlements. The bill makes it a criminal offense to commit a fraudulent life settlement act and provides for criminal and administrative sanctions for violations. It provides a licensing requirement for a person acting as a provider or broker; provides for the expiration and renewal of a broker license, including any applicable licensing fees; allows the commissioner to suspend, revoke, or refuse to renew a license under certain circumstances; and requires fifteen hours of continuing education training biennially. Life settlement contracts and disclosure forms must be filed and approved by TDI, and the bill allows the commissioner to require the submission of advertisements. The bill requires an annual report for policies settled within five years of issuance and provides for an administrative penalty of up to $250 per day of delay ($25,000 in aggregate) for each willful failure to file or respond within 30 days from the date of a written inquiry by TDI on the annual report. The bill allows an insurance company application to ask whether the proposed owner intends to pay premiums with the assistance of premium financing from a lender that will use the policy as collateral for the loan. It prohibits the premium finance loan funds from being used for a purpose other than to pay the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy. It also requires the insurer to respond to requests for verification of coverage within 30 days and requires life settlement providers to notify insurers of life settlements within 20 days. The bill authorizes TDI to conduct examinations of entities involved in the life settlement business.

Annuity Suitability – HB2277 updates Texas Insurance Code Chapter 1115 to the March 2010 NAIC annuity suitability model to clarify what consumer information is to be considered and lists the product factors that impact suitability. It prohibits an insurer from issuing an annuity unless there is a reasonable basis to believe it is suitable for the consumer, with exceptions. The bill establishes standards for an insurer or agent to determine whether an annuity is suitable for a consumer, in part based on the agent/insurer’s required disclosures about the product. The seller of the annuity must make a record of its recommendation. Insurers must create a suitability supervision system and are responsible for violations of the chapter. The bill revises continuing education training requirements for agents on annuities.

Effective September 1, 2011. Texas Insurance Code Section 541.058(b), regarding the waiver of surrender charges, applies only to an exchange of life annuity contracts on or after the September 1, 2011. Texas Insurance Code Chapter 1115, regarding suitability, applies only to a recommendation to purchase, exchange, or replace an annuity contract made on or after June 1, 2012 and any transactions arising from that recommendation.

[HB2292](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02292F.htm) Pharmacy Audits and Prompt Pay --HB2292 adds the term “extrapolation” to the Texas Health Maintenance Organization (HMO) Act and to the Preferred Provider Benefit Plans (PPBPs) Act in the Texas Insurance Code. It prohibits the use of extrapolation to estimate audit results or findings for a group of claims not reviewed by the HMO, PPBP, or the pharmacy benefit manager (PBM). The bill requires an HMO, PPBP, or a PBM that administers claims to provide a pharmacy or pharmacist with reasonable notice of an impending on-site audit not later than the 15th day before the date on which the on-site audit is to occur. It requires electronically submitted pharmacy claims to be paid within 18 days and non-electronic claims within 21 days.

Effective September 1, 2011; for pharmacy benefits provided under a contract, applies only to a contract entered into or renewed on or after September 1, 2011; for pharmacy benefits not provided under a contract, applies only to payment for benefits provided on or after September 1, 2011.

[HB2503](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02503F.htm) Agents’ Licensing **–** HB2503 removes the requirement that TDI must determine that a corporation or partnership is admitted to engage in business in this state by the Secretary of State in order to issue an agent license. The bill has no effect on whether a business is required to register with the Secretary of State under the Texas Business Organizations Code.

Effective September 1, 2011; applies only to a license application filed on or after September 1, 2011.

[HB2605](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02605F.htm) Medical Dispute Resolution, Independent Review Organization (IRO) **--** HB2605 states that a party to a medical dispute is entitled to an administrative hearing with TDI-DWC. The finding of an IRO is binding during the pendency of dispute resolution through contested case hearing and judicial review. If an IRO decision is not appealed, the insurance carrier and network shall comply with the decision of the IRO. An aggrieved party to a certified health care network medical dispute is entitled to a contested case hearing conducted in the same manner as other hearings under Labor Code Section 413.0311. A hearing officer shall consider evidence-based treatment guidelines established by the network. The bill provides that the hearing officer’s decision may be appealed through judicial review if a party is still aggrieved by the decision and that judicial review shall be conducted in the manner for contested case hearings under the Government Code and is governed by the substantial evidence rule.

Effective September 1, 2011; applies to a medical dispute based on a review by an independent review organization under Texas Insurance Code Section 1305.355 that is commenced on or after June 1, 2012.

[HB2699](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB02699E.htm) Insurance Adjusters -- HB2699 modifies the insurance adjuster licensing requirements to redefine “adjuster,” “automated claims adjudication system,” “business entity,” “home state,” and “person.” The bill adds to the list of people excepted from the insurance adjuster licensing requirements to include an individual who: (1) collects claim information from or furnishes claim information to an insured or claimant; (2) enters data into an automated claims adjudication system; and (3) is employed by a licensed independent adjuster or its affiliate under circumstances in which no more than 25 individuals are supervised by a single licensed independent adjuster or a single licensed agent. It further provides that a licensed agent acting as a supervisor in that situation is not required to be licensed as an adjuster. The bill also adds to the definition of who may be licensed as an insurance adjuster by defining “business entity” and specifying that a resident of Canada must successfully pass the adjuster examination and comply with other applicable portions of the Texas Insurance Code Section 4101.053 in order to be licensed.

Effective September 1, 2011; Texas Insurance Code Section 4101.053 applies only to an application for a license filed on or after September 1, 2011.

[HB3004](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB03004F.htm) Prepaid Funeral Contracts --HB3004 extends guaranty fund protections under the Finance Code to include funeral providers and their failure or inability to assume the obligations to the purchasers under prepaid funeral contracts. The bill provides for the funding of the guaranty fund and modifies the composition of the guaranty fund advisory council. It allows the council to hold open or closed meetings by conference call, video conference, or other telecommunication method with certain conditions. It provides for a claim to be asserted against a funeral provider. The bill establishes requirements for a permit holder to ensure the obligations under the prepaid funeral benefit contract are fulfilled by the funeral provider and requires reporting of certain information to the council if the permit holder is unable to find a replacement funeral provider.

Effective June 17, 2011; does not apply to a loss under a prepaid funeral contract sold before June 17, 2011 that arises from or relates to: (1) default attributable to the funeral provider, unless the funeral provider is the contract seller; or (2) bankruptcy, receivership, seizure, or other failure of the funeral provider, unless the funeral provider is also the contract seller.

[HB3017](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB03017F.htm) Discretionary Clauses – HB3017 prohibits discretionary clauses in an HMO evidence of coverage (EOC), a policy of life, accident and health, medical or surgical insurance, or an endowment or annuity contract, including applications or riders. The bill establishes criteria for determining if a clause in an EOC, policy, contract or certificate is a discretionary clause.

Effective June 17, 2011; applies only to a document or EOC that is delivered, issued for delivery or renewed on or after January 1, 2012.

## Senate Bills

[SB0007](http://www.capitol.state.tx.us/tlodocs/821/billtext/html/SB00007F.htm) Health Care Collaboratives (Collaboratives) **--** SB0007 provides for the administration, quality, and efficiency of health care, health and human services, and health benefits programs in Texas. It provides for the formation and governance of collaboratives that will arrange for health care services for insurers, HMOs, and other payors in exchange for payments in cash or kind. The collaboratives may consist of various combinations of physicians, insurers, and other providers. The collaboratives will be certified by TDI with review by the Texas Attorney General and will be able to accept and distribute payments for medical and health care services. Rules implementing regulation of collaboratives are to be adopted by the commissioner and attorney general by September 1, 2012.

Texas Institute of Health Care Quality and Efficiency -- SB0007 establishes the Texas Institute of Health Care Quality and Efficiency that will, among other things, conduct certain studies with the assistance of and in coordination with TDI and make recommendations to the Legislature on how to improve the quality and efficiency of health care.

Medicaid Expansion -- SB0007 allows the expansion of managed care in certain counties in South Texas and makes additional changes to the provision of Medicaid services in the state and promoting efficiencies in the delivery of those services.

State Kids Insurance Program -- SB0007 abolishes the State Kids Insurance Program operated by the Employees Retirement System of Texas (ERS) and directs the Health and Human Services Commission to establish a process in cooperation with ERS to facilitate the enrollment of eligible children in the child health plan program established under the Health and Safety Code Chapter 62 (CHIP) and to ensure that those children maintain continuous health benefit coverage during the transition. The Act requires the Health and Human Services Commission to take any action that the commission determines is necessary and appropriate, including expedited and emergency action, to ensure the timely implementation of the relevant provisions of this bill by its effective date of September 28, 2011, including the adoption of administrative rules, the preparation and submission of any required waivers or state plan amendments, and the preparation and execution of any necessary contract changes or amendments.

Interstate Health Care Compact -- SB0007 adds the Texas Insurance Code Chapter 5002 to enact the Interstate Health Care Compact and specifies the parameters of the entry by Texas into the Compact.

Effective September 28, 2011.

[SB0425](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00425F.htm) P&C Insurance Certificates -- SB0425 requires approval by TDI of certificate of insurance forms that are provided as proof of property and casualty insurance coverage. The bill prohibits property and casualty insurers and agents from issuing certificates of insurance or any other type of document purporting to be a certificate of insurance if the certificate or document alters, amends, or extends the coverage or terms and conditions provided by the insurance policy referenced on the certificate or document. It allows TDI to collect a fee, not to exceed $100, for the filing of a new or amended certificate of insurance form. The bill further contains enforcement provisions that include civil penalties and injunctive relief for violations of Texas Insurance Code Chapter 1811.

Effective September 1, 2011; applies only to a certificate of insurance issued on or after January 1, 2012.

[SB0554](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00554F.htm) Contracts with Dentists -- SB0554 provides that a contract between a dentist and an insurer or HMO may not limit the fee the dentist may charge for a service that is not a covered service. Covered services are defined as those dental care services for which reimbursement is available under the policy or plan or for which reimbursement is available subject to a contractual limitation, such as a co-payment or deductible.

Effective September 1, 2011; only applies to contracts entered into or renewed on or after September 1, 2011.

[SB0567](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00567F.htm)Texas Life and Health Insurance Guaranty Association --SB0567 changes the name of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association to the Texas Life and Health Insurance Guaranty Association to more accurately reflect the association’s purpose. The bill amends current law relating to the operation of the association and certain amounts payable by it. It increases the limit of excluded contractual obligations from amounts in excess of $100,000 to amounts in excess of $250,000 for certain annuity contracts.

Effective September 1, 2011.

[SB0579](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00579F.htm)Prepaid Funeral Benefit Agent Authority –SB0579 changes the authority of a prearrangement life insurance agent to write coverage or a combination of coverages with an initial guaranteed death benefit from a $15,000 limit on any life to a limit that does not exceed the total cost of the prepaid funeral benefits purchased under the prepaid funeral contract.

Effective September 1, 2011; applies to a prepaid funeral contract that is formed on or after the effective date of this Act.

[SB0822](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00822F.htm) Expedited Credentialing of Medical School Physicians -- SB0822 expands the definition of “medical group” in Texas Insurance Code Section 1452.101 to include two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit, as defined or described by Education Code Sections 61.003, 61.501, or 74.601.

Effective September 1, 2011.

[SB0859](http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00859F.htm) Health Group Cooperatives -- SB0859 defines “eligible single-employee business” and provides that cooperatives and insurers may permit such businesses to join a cooperative. The bill also sets forth provisions for the separate elections concerning participation by single employee businesses in cooperatives, and rating. The rating election permits insurers to treat participating employers in the cooperative separately for rating purposes. The bill requires the commissioner to adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative that must include provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain employer-based health benefit plan coverage. The bill also permits employee choice among cooperative plans to be limited.

Employer Contributions for Individual Consumer-Directed Health Plans -- SB0859 authorizes the commissioner by rule, unless it would violate state or federal law, to develop procedures that will allow an employer to make financial contributions to or premium payments for an employee or retiree's individual consumer-directed health insurance policy in a manner that eliminates or minimizes or provides positive state or federal tax consequences to the employer.

Effective June 17, 2011.

\* This listing MAY NOT INCLUDE all bills affecting your insurance business.