Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy
Division 1. Utilization Reviews
28 TAC §19.1703

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §19.2003

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §19.1703 and §19.2003, concerning utilization reviews for health care. The amendments to §19.1703 and §19.2003 implement House Bill 446, 88th Legislature, 2023.

EXPLANATION. Sections 19.1703 and 19.2003 provide definitions for TDI rules relating to utilization reviews for health care provided under a health plan or workers' compensation insurance coverage, including the definition of the term "person." The amendments to §19.1703 and §19.2003 update the definition of "person" in §19.1703(b)(22) and §19.2003(b)(25) to replace the words "mental retardation" with "intellectual disability," in alignment with HB 446, which updated the definition of "person" in Insurance Code §1305.004.

In a separate rulemaking, as part of the implementation of HB 446, TDI proposes to amend 28 TAC §3.3052, concerning standards for termination of insurance provision, to similarly update references to the term "mental retardation." The proposed Chapter 3 amendments are also published in this issue of the *Texas Register*.

In addition, the proposed amendments include nonsubstantive rule drafting and formatting changes to conform the sections to the agency's current style and to improve the rules' clarity.

In §19.1703, these changes include inserting the titles of cited Insurance Code provisions in subsections (a), (b)(5), (b)(6)(A), (b)(14), (b)(22), and (b)(24)(A) and necessary punctuation updates related to the change in subsection (b)(22); inserting the title of a cited Government Code provision in subsection (b)(17)(A); italicizing *Diagnostic and Statistical Manual of Mental Disorders* in subsection (b)(21); changing "prior to" to "before" in subsection (b)(26)(A) - (C) for plain language purposes; and changing "re-certification" to "recertification" in subsection (b)(35).

In §19.2003, these changes include inserting the titles of cited Insurance Code provisions in subsections (a), (b)(5), (b)(7)(A), (b)(25), (b)(39), and (b)(43); inserting the titles of cited Labor Code provisions in subsections (b)(2), (b)(6), and (b)(40); inserting the title of a cited Government Code provision in subsection (b)(16)(A); adding a comma in subsection (b)(2); italicizing *Diagnostic and Statistical Manual of Mental Disorders* in subsection (b)(22); changing "prior to" to "before" in subsection (b)(28)(A) - (C) for plain language purposes; and removing an incorrect comma in subsection (b)(30).

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments, other than that imposed by statute. Ms. Bowden made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Bowden does not anticipate measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Bowden expects that administering or enforcing the proposed amendments will have the public benefit of ensuring that TDI's rules align with changes made by HB 446.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance because they do not impose requirements.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses or on rural communities because the amendments merely update statutory language by replacing an out-of-date term and make other nonsubstantive changes that do not affect costs. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Therefore, no additional rule amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on September 22, 2025. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by TDI no later than 5:00 p.m., central time, on September 22, 2025. If a public hearing is held, TDI will consider written and oral comments presented at the hearing.

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy
Division 1. Utilization Reviews
28 TAC §19.1703

STATUTORY AUTHORITY. TDI proposes amendments to §19.1703 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. Section 19.1703 implements Insurance Code §1305.004.

TEXT.

§19.1703. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201, concerning Utilization Review Agents, have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. The

term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(2) Appeal--A URA's formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a URA under §19.1704 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001, concerning Definitions.

(6) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351, concerning Complaint as Appeal; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) Declination--A response to a request for verification in which an HMO or preferred provider benefit plan does not issue a verification for proposed medical care or

health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Insurance Code or applicable TDI rules, or any other association with the enrollee, employer, insurance carrier, or HMO that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device[,] but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(13) Health coverage--Payment for health care services provided under a health benefit plan or a health insurance policy.

(14) Health maintenance organization or HMO--As defined in Insurance Code §843.002, concerning Definitions.

(15) Insurance carrier or insurer--An entity authorized and admitted to do the business of insurance in Texas under a certificate of authority issued by TDI.

(16) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(17) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a), concerning Dates and Descriptions of Holidays;

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(18) Medical records--The history of diagnosis and treatment, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an enrollee.

(19) Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's need for treatment of a mental or emotional condition or disorder, including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of enrollee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(20) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, a psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(21) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current *Diagnostic and Statistical Manual of Mental Disorders* [~~Diagnostic and Statistical Manual of Mental Disorders~~].

(22) Person--Any individual;[,] partnership;[,] association;[,] corporation;[,] organization;[,] trust;[,] hospital district;[,] community mental health center;[,] intellectual disability [~~mental retardation~~] center;[,] mental health and intellectual disability [~~mental retardation~~] center;[,] limited liability company;[,] limited liability partnership;[,] the statewide rural health care system under Insurance Code Chapter 845, concerning Statewide Rural Health Care System;[,] and any similar entity.

(23) Preauthorization--A form of prospective utilization review by a payor or its URA of health care services proposed to be provided to an enrollee.

(24) Preferred provider--

(A) with regard to a preferred provider benefit plan, a preferred provider as defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans.

(B) with regard to an HMO:

(i) a physician, as defined in Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined in Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(25) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the enrollee or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the enrollee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(26) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours before [~~prior to~~] issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day before [~~prior to~~] issuing a prospective utilization review adverse determination;

(B) no less than five working days before [~~prior to~~] issuing a retrospective utilization review adverse determination; or

(C) before [~~prior to~~] issuing a concurrent or post-stabilization review adverse determination.

(27) Registration--The process for a licensed insurance carrier or HMO to register with TDI to perform utilization review solely for its own enrollees.

(28) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA.

(29) Retrospective utilization review--A form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(30) Routine vision services--A routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(31) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by the URA as part of the utilization review process.

(32) TDI--The Texas Department of Insurance.

(33) URA--Utilization review agent.

(34) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(35) Verification--A guarantee by an HMO or preferred provider benefit plan that the HMO or preferred provider benefit plan will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the enrollee for whom the services are proposed. The term includes pre-certification, certification, recertification [~~re-certification~~], and any other term that would be a reliable representation by an HMO or preferred provider benefit plan to a physician or provider if the request for the pre-certification, certification, recertification [~~re-certification~~], or representation includes the requirements of §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §19.2003

STATUTORY AUTHORITY. TDI proposes §19.2003 under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the commissioner may adopt rules as necessary to implement Chapter 1305.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. Section 19.2003 implements Insurance Code §1305.004.

TEXT.

§19.2003. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201, concerning Utilization Review Agents, have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational.

(2) Appeal--The URA's formal process by which an injured employee, an injured employee's representative, or an injured employee's provider of record may request reconsideration of an adverse determination. For the purposes of this subchapter, the term also applies to reconsideration processes prescribed by Labor Code Title 5, concerning Workers' Compensation, and applicable rules for workers' compensation.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued

to an insurance carrier that is registered as a URA under §19.2004 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001, concerning Definitions.

(6) Compensable injury--As defined in Labor Code §401.011, concerning General Definitions.

(7) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351, concerning Complaint as Appeal; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(8) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other

services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under Labor Code or applicable TDI-DWC rules, Insurance Code or applicable TDI rules, or any other association with the injured employee, employer, or insurance carrier that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--As defined in Labor Code §401.011.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care--As defined in Labor Code §401.011.

(13) Health care facility--As defined in Labor Code §401.011.

(14) Insurance carrier or insurer--As defined in Labor Code §401.011.

(15) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(16) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a), concerning Dates and Descriptions of Holidays;

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(17) Medical benefit--As defined in Labor Code §401.011.

(18) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the injured employee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(19) Medical records--The history of diagnosis of and treatment for an injury, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an injured employee.

(20) Mental health medical record summary--A summary of process or progress notes relevant to understanding the injured employee's need for treatment of a mental or emotional condition or disorder including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of injured employee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(21) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(22) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current *Diagnostic and Statistical Manual of Mental Disorders* [~~Diagnostic and Statistical Manual of Mental Disorders~~].

(23) Payor--Any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits, including workers' compensation benefits, to an individual treated by a health care provider under a policy, plan, statute, or contract.

(24) Peer review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(25) Person--Any individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, intellectual disability [~~mental retardation~~] center, mental health and intellectual disability [~~mental retardation~~] center, limited liability company, limited liability partnership, a political subdivision of this state, the statewide rural health care system under Insurance Code Chapter 845, concerning Statewide Rural Health Care System, and any similar entity.

(26) Preauthorization--A form of prospective utilization review by a payor or a payor's URA of health care services proposed to be provided to an injured employee.

(27) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of an injured employee, or a physician, doctor, or other health care provider that has rendered or has been requested to provide health care services to an injured employee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(28) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours before [~~prior to~~] issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day before [~~prior to~~] issuing a prospective utilization review adverse determination;

(B) no less than five working days before [~~prior to~~] issuing a retrospective utilization review adverse determination; or

(C) before [~~prior to~~] issuing a concurrent or post-stabilization review adverse determination.

(29) Registration--The process for an insurance carrier to register with TDI to perform utilization review solely for injured employees covered by workers' compensation insurance coverage issued by the insurance carrier.

(30) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA[,] or insurance carrier that made the adverse determination.

(31) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(32) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by a URA as part of the utilization review process.

(33) TDI--The Texas Department of Insurance.

(34) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(35) Texas Workers' Compensation Act--Labor Code Title 5, Subtitle A.

(36) Treating doctor--As defined in Labor Code §401.011.

(37) URA--Utilization review agent.

(38) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(39) Workers' compensation health care network--As defined in Insurance Code §1305.004, concerning Definitions.

(40) Workers' compensation health plan--Health care provided by a political subdivision contracting directly with health care providers or through a health benefits pool, under Labor Code §504.053(b)(2), concerning Election.

(41) Workers' compensation insurance coverage--As defined in Labor Code §401.011.

(42) Workers' compensation network coverage--Health care provided under a workers' compensation health care network.

(43) Workers' compensation non-network coverage--Health care delivered under Labor Code Title 5, excluding health care provided under Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks.

CERTIFICATION. The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Issued in Austin, Texas, on August 5, 2025.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance