WEST VIRGINIA LEGISLATURE

SENATE JOURNAL

EIGHTY-FOURTH LEGISLATURE
REGULAR SESSION, 2019
TWENTY-FIRST DAY

Charleston, West Virginia, Tuesday, January 29, 2019

The Senate met at 11:13 a.m.

(Senator Carmichael, Mr. President, in the Chair.)

Prayer was offered by Pastor Bo Burgess, Jordan Baptist Church, Gallipolis Ferry, West Virginia.

The Senate was then led in recitation of the Pledge of Allegiance by the Honorable Mark R. Maynard, a senator from the sixth district.

Pending the reading of the Journal of Monday, January 28, 2019,

At the request of Senator Trump, unanimous consent being granted, the Journal was approved and the further reading thereof dispensed with.

The Senate proceeded to the second order of business and the introduction of guests.

The Senate then proceeded to the third order of business.

A message from the Clerk of the House of Delegates announced the passage by that body and requested the concurrence of the Senate in the passage of

Eng. Com. Sub. for House Bill 2005—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §11-6L-1, §11-6L-2, §11-6L-3, §11-6L-4, and §11-6L-5, to amend said code by adding thereto three new sections, designated §31G-4-4, §31G-4-5, and §31G-4-6, and to amend said code by adding thereto a new chapter, designated §31H-1-1, §31H-1-2, §31H-2-1, §31H-2-2, §31H-2-3, and §31H-2-4, all relating to wireless telecommunication technology facilities generally; providing a special method for valuation of certain wireless technology property for property taxes; defining terms; providing mandated salvage valuation of certain wireless businesses' property; specifying method for valuation of certain property; requiring initial determination and specifying procedure for protest and appeal of determination; establishing Public Service Commission jurisdiction over make-ready pole access within the state; relating to the determination of the feasibility of electric utilities constructing and operating middle-mile broadband internet projects to serve certain unserved and underserved areas; defining certain terms; delineating the factors that must be contained in certain feasibility

studies; requiring the Broadband Enhancement Council and the Public Service Commission to assist electric utilities in the determination of the feasibility of certain proposed middle-mile broadband development projects; requiring that the Broadband Enhancement Council render a judgment as to the feasibility of middle-mile broadband internet projects within a certain period of time; requiring certain reports be submitted to certain officials and committees; and providing for severability; the establishment of the West Virginia Small Wireless Facilities Deployment Act; making legislative findings; defining terms; providing for access to public rights-of-way for the collocation of small wireless facilities; providing for certain permit requirements; authorizing and limiting access to collocation sites, structures and equipment; requiring permits to be issued on a nondiscriminatory basis; providing for the collection of fees and setting the amount of fees; and providing for certain zoning, indemnification, insurance, and bonding requirements.

Referred to the Committee on Government Organization; and then to the Committee on Finance.

A message from the Clerk of the House of Delegates announced the passage by that body and requested the concurrence of the Senate in the passage of

Eng. House Bill 2036—A Bill to amend and reenact §17C-13-6 of the Code of West Virginia, 1931, as amended, relating to permitting vehicles displaying disabled veterans special registration plates to park in places where persons with mobility impairments may park.

Referred to the Committee on Military.

A message from the Clerk of the House of Delegates announced the passage by that body and requested the concurrence of the Senate in the passage of

Eng. House Bill 2209—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §30-24-8, relating to allowing military veterans who meet certain qualifications to qualify for examination for license as an emergency medical technician.

Referred to the Committee on Military.

A message from the Clerk of the House of Delegates announced the passage by that body and requested the concurrence of the Senate in the passage of

Eng. House Bill 2547—A Bill to amend and reenact §3-9-6 of the Code of West Virginia, 1931, as amended, relating to the election prohibition zone; amending the election prohibition zone from 300 feet to 100 feet.

Referred to the Committee on the Judiciary.

A message from the Clerk of the House of Delegates announced the passage by that body and requested the concurrence of the Senate in the passage of

Eng. Com. Sub. for House Bill 2600—A Bill to amend and reenact §3-4A-15 of the Code West Virginia, 1931, as amended, relating to publication of facsimile sample ballots.

Referred to the Committee on the Judiciary.

The Senate proceeded to the fourth order of business.

Senator Azinger, from the Committee on Banking and Insurance, submitted the following report, which was received:

Your Committee on Banking and Insurance has had under consideration

Senate Bill 30, Eliminating tax on annuity considerations collected by life insurer.

And has amended same.

And reports the same back with the recommendation that it do pass, as amended; but under the original double committee reference first be referred to the Committee on Finance.

Respectfully submitted,

Michael T. Azinger,
Chair.

The bill, under the original double committee reference, was then referred to the Committee on Finance, with an amendment from the Committee on Banking and Insurance pending.

Senator Blair, from the Committee on Finance, submitted the following report, which was received:

Your Committee on Finance has had under consideration

Com. Sub. for Senate Bill 103, Relating generally to Public Defender Services.

And,

Com. Sub. for Senate Bill 264, Requiring courts to order restitution to crime victims where economically practicable.

And reports the same back with the recommendation that they each do pass.

Respectfully submitted,

Craig Blair,
Chair.

Senator Trump, from the Committee on the Judiciary, submitted the following report, which was received:

Your Committee on the Judiciary has had under consideration

Senate Bill 266, Creating Intermediate Court of Appeals and WV Appellate Review Organization Act of 2019.

And reports back a committee substitute for same with the following title:

Com. Sub. for Senate Bill 266 (originating in the Committee on the Judiciary)—A Bill to amend and reenact §3-10-3a of the Code of West Virginia, 1931, as amended; to amend and reenact §23-5-15 of said code; to amend and reenact §29A-5-4 of said code; to amend and reenact §29A-6-1 of said code; to amend said code by adding thereto a new section, designated §51-2A-24; to amend and reenact §51-9-1a of said code; to amend said code by adding thereto a new article, designated §51-11-1, §51-11-2, §51-11-3, §51-11-4, §51-11-5, §51-11-6, §51-11-7, §51-11-8, §51-11-9, §51-11-10, §51-11-11, §51-11-12, and §51-11-13; and to amend and reenact §58-5-1 of said code, all relating generally to the West Virginia Appellate Reorganization Act of 2019, creating an Intermediate Court of Appeals in West Virginia; providing that the Judicial Vacancy Advisory Commission shall assist the Governor in filling judicial vacancies in the Intermediate Court of Appeals; providing that petitions for review of final decisions of the Workers' Compensation Board of Review must be made to the Intermediate Court of Appeals and that petitioners have a right to review in such court; providing that the Supreme Court of Appeals has discretion to review final decisions of the Intermediate Court of Appeals in workers' compensation claims; providing that the Workers' Compensation Board of Review may continue to certify questions of law directly to the Supreme Court of Appeals; requiring that appeal of contested cases under State Administrative Procedures Act be made to the Intermediate Court of Appeals; transferring jurisdiction to review family court final orders from circuit courts to the Intermediate Court of Appeals; placing judges of Intermediate Court of Appeals under the judicial retirement system; establishing the Intermediate Court of Appeals by a certain date; providing a short title; providing legislative findings; defining terms; requiring a three-judge panel for proceedings; authorizing jurisdiction of the Intermediate Court of Appeals over certain matters; specifically excluding certain matters from jurisdiction of the Intermediate Court of Appeals; providing eligibility criteria for judges of the Intermediate Court of Appeals; providing a process for initial appointment of judges to the Intermediate Court of Appeals to staggered judicial terms and to ten year terms on the expiration of terms thereafter; providing for the filling of vacancies in unexpired judicial terms by appointment; providing that the Governor's appointments are subject to Senate confirmation; providing that judges of the Intermediate Court of Appeals may not be candidates for any elected public office during judicial term; establishing certain requirements for the filing of appeals to the Intermediate Court of Appeals; clarifying that an appeal bond may be required before appeal to the Intermediate Court of Appeals may take effect; requiring the Chief Judge of the Intermediate Court of Appeals to publish and submit certain reports to the Legislature and Supreme Court of Appeals regarding pending cases; authorizing filing fees; providing for deposit of filing fees in a special revenue account to fund the State Police Forensic Laboratory; recognizing the constitutional authority of the Supreme Court of Appeals to exercise administrative authority over the Intermediate Court of Appeals; providing that procedures and operations of the Intermediate Court of Appeals shall comply with rules promulgated by the Supreme Court of Appeals; requiring that appeals to the Intermediate Court of Appeals be filed with the Clerk of the Supreme Court of Appeals; providing that Intermediate Court of Appeals proceedings shall take place in publicly available facilities as arranged by the Administrative Director of the Supreme Court of Appeals; granting the Intermediate Court of Appeals discretion to require oral argument; authorizing the Administrative Director of the Supreme Court of Appeals to employ staff for Intermediate Court of Appeals operations; providing that the budget for Intermediate Court of Appeals operations shall be included in the appropriation for the Supreme Court of Appeals; authorizing the Intermediate Court of Appeals to issue opinions as binding precedent for lower courts; providing for discretionary review of Intermediate Court of Appeals decisions by Supreme Court of Appeals; authorizing an annual salary, retirement benefits, and reimbursement of expenses for judges of the Intermediate Court of Appeals; providing for reimbursement of expenses of Intermediate Court of Appeals staff; providing that certain appeals are reviewed and a written decision issued by either the Intermediate Court of Appeals or the

Supreme Court of Appeals, as a matter of right; removing obsolete language from the Code; and making technical corrections to the Code.

With the recommendation that the committee substitute do pass; but under the original double committee reference first be referred to the Committee on Finance.

Respectfully submitted,

Charles S. Trump IV,
Chair.

The bill (Com. Sub. for S. B. 266), under the original double committee reference, was then referred to the Committee on Finance.

Senator Maynard, from the Committee on Natural Resources, submitted the following report, which was received:

Your Committee on Natural Resources has had under consideration

Senate Bill 331, Using leashed dogs to track mortally wounded deer or bear.

And,

Senate Bill 332, Relating to Class Q special hunting permit for disabled persons.

And reports the same back with the recommendation that they each do pass.

Respectfully submitted,

Mark R. Maynard,
Chair.

The Senate proceeded to the sixth order of business.

At the request of Senator Takubo, unanimous consent being granted, the following bills were considered introduced, read by their titles, and referred to the appropriate committees as shown on the Chamber Automation System:

By Senators Carmichael (Mr. President) and Prezioso (By Request of the Executive):

Senate Bill 452—A Bill making a supplementary appropriation of public moneys out of the Treasury from the balance of moneys remaining unappropriated for the fiscal year ending June 30, 2019, to the Department of Military Affairs and Public Safety, Division of Justice and Community Services – Second Chance Driver's License Program Account, fund 6810, fiscal year 2019, organization 0620, by supplementing and amending the appropriations for the fiscal year ending June 30, 2019.

Referred to the Committee on Finance.

By Senators Azinger and Cline:

Senate Bill 453—A Bill to amend and reenact §31A-2-4 of the Code of West Virginia, 1931, as amended, relating to background checks of certain financial institutions; allowing commissioner

to accept alternate report forms in limited circumstances for certain non-United States based principals or owners; and making technical corrections.

Referred to the Committee on Banking and Insurance.

By Senators Maynard, Roberts, Sypolt, and Cline:

Senate Bill 454—A Bill to amend and reenact §16-3-4 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §18B-1-12; and to amend and reenact §21-1A-3 of said code, all relating to exemptions from mandated immunizations.

Referred to the Committee on Health and Human Resources; and then to the Committee on the Judiciary.

By Senator Blair:

Senate Bill 455—A Bill to amend and reenact §11-12-19 of the Code of West Virginia, 1931, as amended; and to amend and reenact §11-15-8b of said code, all relating generally to contractors; defining certain terms; clarifying business registration requirements in case of both nonresident contractors and nonresident subcontractors; clarifying bonding requirements in case of both nonresident contractors and nonresident subcontractors for purposes of consumers sales and service tax and use tax; and including municipal consumers sales and use taxes and special district excise tax within bonding specifications, as applicable.

Referred to the Committee on Finance.

By Senator Blair:

Senate Bill 456—A Bill to amend and reenact §11-14C-9 of the Code of West Virginia, 1931, as amended, relating to authorizing railroads and commercial watercraft to claim a refundable exemption from the variable rate component of the motor fuel excise tax; and removing the aggregate annual exemption limitation imposed on railroads, all beginning July 1, 2019.

Referred to the Committee on Finance.

By Senators Blair, Cline, Roberts, and Maroney:

Senate Bill 457—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §11-15-9q, relating to exempting sales by not-for-profit and volunteer school support organizations for the purpose of raising funds for their schools from the consumers sales and service tax and use tax; specifying time limitations for fundraisers; specifying the exemption applies without regard to whether the organization holds, or does not hold, an exemption under §501(c)(3) or §501(c)(4) of the Internal Revenue Code.

Referred to the Committee on Finance.

By Senator Clements:

Senate Bill 458—A Bill to amend and reenact §17C-7-1 and §17C-7-3 of the Code of West Virginia, 1931, as amended; and to amend and reenact §17C-8-8 of said code, all relating to traffic regulations; increasing fines; permitting visible instead of audible signal when passing to the left of an overtaken vehicle; and clarifying that an appropriate signal is required when moving right or left upon a roadway.

Referred to the Committee on Transportation and Infrastructure; and then to the Committee on the Judiciary.

By Senators Baldwin, Plymale, Jeffries, Beach, and Hamilton:

Senate Bill 459—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §60A-9A-1, §60A-9A-2, §60A-9A-3, §60A-9A-4, §60A-9A-5, and §60A-9A-6, all relating to requiring wholesale drug distributors to report certain information to the West Virginia Board of Pharmacy.

Referred to the Committee on Health and Human Resources; and then to the Committee on Finance.

By Senators Boso, Plymale, Cline, Tarr, and Maroney:

Senate Bill 460—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §21-1E-1, §21-1E-2, §21-1E-3, §21-1E-4, and §21-1E-5; and to amend said code by adding thereto a new article, designated §30-1E-1, §30-1E-2, §30-1E-3, and §30-1E-4, all relating to requiring standards and procedures for recognizing career technical training acquired in public schools, apprenticeship programs, and employer-sponsored training programs toward occupational testing, certification, and/or licensure; establishing purpose and intent; providing definitions; requiring rules providing standards and procedures be proposed by Commissioner of Labor and by licensing boards and commissions; providing for creation of lists of existing apprenticeships, certifications, and other credentials that reflect existing workforce needs and for dissemination to high school students; and requiring Commissioner of Labor rule to include guidelines for collection and dissemination in manner easily accessible to both students and their parents.

Referred to the Committee on Education.

By Senator Blair:

Senate Bill 461—A Bill to amend and reenact §11-21-77 of the Code of West Virginia, 1931, as amended; and to amend and reenact §29-22-15a of said code, all relating generally to lottery prizes; defining terms; extending personal income tax withholding requirements to certain lottery winnings; designating lottery winnings as source of income; specifying gross prize threshold for lottery winner anonymity election; specifying exemption from Freedom of Information Act; specifying treatment of lottery pool members; eliminating fee for anonymity option election; specifying limitations and exceptions to anonymity pursuant to lawful legal process, disclosure to local, state, or federal tax agencies, and agencies lawfully entitled to information; authorizing promulgation of rules; specifying method for determining value of gross prize; and specifying effective date.

Referred to the Committee on Finance.

By Senators Blair and Cline:

Senate Bill 462—A Bill to amend and reenact §11-15-17 of the Code of West Virginia, 1931, as amended, relating to officer liability for unremitted consumers sales and service tax.

Referred to the Committee on Finance.

By Senator Sypolt:

Senate Bill 463—A Bill to amend and reenact §44-1-29 of the Code of West Virginia, 1931, as amended, relating to authorization for a personal representative, trustee, administrator, or

executor of a deceased person's estate to transfer or amend conservation or preservation easements; defining the duty of the personal representative, trustee, administrator, or executor; and establishing conditions for the exercise of the authority to transfer or amend.

Referred to the Committee on the Judiciary.

By Senators Blair and Cline:

Senate Bill 464—A Bill to amend and reenact §30-3-13 and §30-3-13a of the Code of West Virginia, 1931, as amended, all relating to modifying licensing requirements for the practice of telemedicine and surgery or podiatry; and providing exceptions, notice requirements, and criminal penalties.

Referred to the Committee on Government Organization.

By Senators Sypolt, Clements, Hamilton, Maroney, Maynard, Smith, Swope, Tarr, Weld, Plymale, Roberts, and Cline:

Senate Bill 465—A Bill to amend and reenact §23-2-1a of the Code of West Virginia, 1931, as amended, relating to exempting nonpaid volunteers at a volunteer fire department or emergency medical services organization who volunteer for the purpose of fundraising, or other administrative capacity, from workers' compensation benefits.

Referred to the Committee on Banking and Insurance.

By Senators Maynard, Roberts, Sypolt, and Cline:

Senate Bill 466—A Bill to amend and reenact §17-2A-11 of the Code of West Virginia, 1931, as amended, relating to modifying the road classifications which the Division of Highways is to use when maintaining its digital road map.

Referred to the Committee on Transportation and Infrastructure.

By Senators Boso, Roberts, and Cline:

Senate Bill 467—A Bill to amend and reenact §8-12-17 of the Code of West Virginia, 1931, as amended; to amend and reenact §8-16-18 of said code; to amend and reenact §8-19-4 of said code; to amend and reenact §8-20-10 of said code; to amend and reenact §16-13-16 of said code; to amend and reenact §16-13A-9 of said code; to amend and reenact §24-1-1 of said code; to amend and reenact §24-2-1, §24-2-2, §24-2-3, §24-2-4a, §24-2-4b, and §24-2-11 of said code, all relating to clarifying Public Service Commission jurisdiction over water and sewer utilities owned by political subdivisions; establishing uniformity in the class of publications required by municipalities and public service districts for the revision in rates; providing a time period for the filing of and resolution of complaints filed at the Public Service Commission regarding actions of municipalities; cleaning up language regarding reference to other sections of the code regarding notice requirements for municipal utilities; and regarding the time period pertaining to the filing of appeals and the resolution of the appeals for rate and construction projects decided by county commissions.

Referred to the Committee on Government Organization.

The Senate proceeded to the seventh order of business.

Senate Concurrent Resolution 18, Curtis "Pap" and Millie "Mammie" Asbury Memorial Bridge.

On unfinished business, coming up in regular order, was reported by the Clerk and referred to the Committee on Transportation and Infrastructure.

The Senate proceeded to the eighth order of business.

Eng. Senate Bill 63, Relating to partial filling of prescriptions.

On third reading, coming up in regular order, was read a third time and put upon its passage.

Pending discussion,

The question being "Shall Engrossed Senate Bill 63 pass?"

On the passage of the bill, the yeas were: Azinger, Baldwin, Beach, Blair, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Mann, Maroney, Maynard, Palumbo, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—33.

The nays were: None.

Absent: Boley—1.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. S. B. 63) passed.

The following amendment to the title of the bill, from the Committee on Health and Human Resources, was reported by the Clerk and adopted:

Eng. Senate Bill 63—A Bill to amend and reenact §30-5-27 of the Code of West Virginia, 1931, as amended, relating to partial filling of prescriptions; permitting partial filling of prescriptions for controlled substances listed in Schedule II under certain circumstances; setting conditions for partial filling of prescriptions for controlled substances listed in Schedule II; permitting remaining portion of prescription to be filled within 30 days of first partial filling; setting forth steps to be followed if pharmacist is unable to fill remaining portion of prescription; prohibiting further quantities from being supplied beyond 30 days in absence of new prescription; providing that remaining portions of a partially filled prescription for controlled substances listed in Schedule II may be filled in emergency situations; and defining "emergency situation".

Ordered, That the Clerk communicate to the House of Delegates the action of the Senate and request concurrence therein.

Eng. Senate Bill 233, Relating to age requirements for deputy sheriff.

Having been read a third time on yesterday, Monday, January 28, 2019, and now coming up in regular order, was reported by the Clerk.

At the request of Senator Boso, unanimous consent being granted, the bill was laid over one day, retaining its place on the calendar.

Eng. Com. Sub. for Senate Bill 236, Providing notice of eligibility to persons to vote after completion of punishment or pardon.

On third reading, coming up in regular order, was read a third time and put upon its passage.

On the passage of the bill, the yeas were: Azinger, Baldwin, Beach, Blair, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Mann, Maroney, Maynard, Palumbo, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—32.

The nays were: Tarr—1.

Absent: Boley—1.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. Com. Sub. for S. B. 236) passed with its title.

Ordered, That the Clerk communicate to the House of Delegates the action of the Senate and request concurrence therein.

The Senate proceeded to the ninth order of business.

Com. Sub. for Senate Bill 4, Relating generally to Municipal Home Rule Program.

On second reading, coming up in regular order, was read a second time.

On motion of Senator Romano, the following amendment to the bill was reported by the Clerk:

On page nine, section five-a, line one hundred seventy-two, by striking out all of subdivision (22);

And,

By renumbering the remaining subdivisions.

Following extended discussion,

The question being on the adoption of Senator Romano’s amendment to the bill (Com. Sub. for S. B. 4), the same was put.

The result of the voice vote being inconclusive, Senator Romano demanded a division of the vote.

A standing vote being taken, there were 11 “yeas” and 21 “nays”.

Whereupon, Senator Carmichael (Mr. President) declared Senator Romano’s amendment to the bill rejected.

At the request of Senator Palumbo, and by unanimous consent, the bill (Com. Sub. for S. B. 4) was advanced to third reading with the right for further amendments to be considered on that reading.

Com. Sub. for Senate Bill 72, Creating Sexual Assault Victims’ Bill of Rights.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Com. Sub. for Senate Bill 102, Relating generally to powers and authority of courthouse security officers.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Senate Bill 149, Exempting certain veterans from concealed weapons license fees.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Com. Sub. for Senate Bill 199, Authorizing certain miscellaneous agencies and boards promulgate legislative rules.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Com. Sub. for Senate Bill 243, Requiring racetrack participate in WV Thoroughbred Development Fund.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Senate Bill 256, Allowing certain deductions from individual personal income tax refunds.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Com. Sub. for Senate Bill 258, Establishing common law “veil piercing” claims not be used to impose personal liability.

On second reading, coming up in regular order, was read a second time.

On motion of Senator Lindsay, the following amendment to the bill was reported by the Clerk:

By striking out everything after the enacting clause and inserting in lieu thereof the following:

ARTICLE 3. RELATIONS OF MEMBERS AND MANAGERS TO PERSONS DEALING WITH LIMITED LIABILITY COMPANY.

§31B-3-303. Liability of members and managers.

(a) Except as otherwise provided in §31B-3-303(c) of this code, the organizational statute of a limited liability company, other statutes regulating the activities and operations of a limited liability company, or by express agreement of the members, the debts, obligations, and liabilities of a limited liability company, whether arising in contract, tort, or otherwise, are solely the debts, obligations, and liabilities of the company. A member or manager is not personally liable for a debt, obligation, or liability of the company solely by reason of being or acting as a member or manager. It is the intent and policy of the Legislature that for any claim against a limited liability

company arising after the effective date of the reenactment of this section during the regular session of the Legislature, 2019, common law corporate "veil piercing" claims may not be used to impose personal liability on a member or manager of a limited liability company, and that the West Virginia Supreme Court of Appeals decision in *Joseph Kubican v. The Tavern, LLC,* 232 W.Va. 268, 752 S.E. 2d 299 (2013) be nullified.

(b) The failure of a limited liability company to observe the usual company formalities or requirements relating to the exercise of its company powers or management of its business is not a ground for imposing personal liability on the members or managers for liabilities of the company.

(c) All or specified members of a limited liability company are liable in their capacity as members for all or specified debts, obligations, or liabilities of the company, whether in tort, contract, or otherwise, if:

~~(1) A provision to that effect is contained in the articles of organization; and~~

~~(2) A member so liable has consented in writing to the adoption of the provision or to be bound by the provision~~. the limited liability company is or becomes insolvent and:

(1) The member, either directly or through representations made through the limited liability company, commits actual fraud which causes injury to an individual or entity.

(2) The member, either directly or through representations made through the limited liability company, is shown through acts or omissions to have committed constructive fraud, and he or she is shown to have committed or participated in one or more wrongful acts.

(3) The limited liability company participates in a conflicted exchange; or

(4) The limited liability company makes an insolvency distribution to the owner.

(d) Definitions. As used in this section:

"Conflicted exchange" means a transfer of money or other property from a limited liability company to a member of the limited liability company (or to any other organization in which the member has a material financial interest) in exchange for services, goods, or other tangible or intangible property of less than reasonable equivalent value.

"Creditor" means a person or organization to which the limited liability company is indebted based on a contract or other voluntary transaction between the limited liability company and the creditor. "Creditor" includes, for example, employees, customers, trade creditors, and lenders. The term "creditor" does not include toward claimants or governmental agency seeking to impose statutory obligations.

"Insolvency distribution" means a transfer of money or other property from a limited liability company to a member of that limited liability company (or to any other organization in which the member has a material financial interest), in respect of the member's ownership interest, that renders the limited liability company insolvent.

"Insolvent" means, with respect to a limited liability company, that the limited liability company is unable to pay its debts in the ordinary course of business. Claims that are unusual in nature or

amount, including tort claims in claims for consequential damages, are not to be considered claims in the ordinary course of business for the purposes of this section.

"Member" means any person or organization that, by reason of an ownership interest, is entitled to share in the profits of the limited liability company.

"Wrongful acts" means one or more of the following:

(1) Commingling - whether members and managers fail to keep business funds and accounts separate from funds and accounts of members, (or) whether members fail to keep their personal books and financial accounts and records separate from the accounts of the limited liability company;

(2) Siphoning of Funds - whether the manager or majority member has siphoned funds from the limited liability company in violation of the articles of organization, the operating agreement, or this article;

(3) Gross Undercapitalization - at the time of its formation, or at the time of the litigated transaction or occurrence, whether the limited liability company was grossly undercapitalized or underinsured, rendering the business unable to satisfy the reasonably anticipated debts and expenses of the limited liability company incurred in the ordinary course of business;

(4) Public Notice of the limited liability company - whether the members fail to hold the business out as a separate legal entity;

(5) The Members Usurp Power - whether the members make decisions for the limited liability company, thereby usurping the power of the managers, in direct contravention of the articles of organization and/or operating agreement;

(6) Disrespect of the Separate Legal Entity - whether the members acted in such a way as to fail to respect the separate legal existence of the limited liability company, as shown by such acts as using limited liability company credit to secure personal loans, distributing limited liability company earnings to members through nonauthorized means, members using limited liability company property as if it were their own, or other usage of the limited liability company by members for personal transactions;

(7) Improper Purpose of Formation - whether the limited liability company was organized with the purpose of avoiding contractual liabilities or circumventing regulatory statutes or common law duties.

(8) Breach of Fiduciary Relationship - whether the members' acts constituted a breach of a legal or equitable duty owed to the injured party, thereby violating a fiduciary relationship.

Following extended discussion and points of inquiry to the President, with resultant responses thereto,

The question being on the adoption of Senator Lindsay's amendment to the bill, the same was put and did not prevail.

On motion of Senator Trump, the following amendment to the bill (Com. Sub. for S. B. 258) was next reported by the Clerk:

By striking out everything after the enacting clause and inserting in lieu thereof the following:

ARTICLE 3. RELATIONS OF MEMBERS AND MANAGERS TO PERSONS DEALING WITH LIMITED LIABILITY COMPANY.

§31B-3-303. Liability of members and managers.

(a) Except as otherwise provided in §31B-3-303(c) of this code, the debts, obligations and liabilities of a limited liability company, whether arising in contract, tort or otherwise, are solely the debts, obligations and liabilities of the company. A member or manager is not personally liable for a debt, obligation or liability of the company solely by reason of being or acting as a member or manager. It is the intent and policy of the Legislature that for any claim against a limited liability company arising after the effective date of the reenactment of this section during the regular session of the Legislature, 2019, common law corporate "veil piercing" claims may not be used to impose personal liability on a member or manager of a limited liability company, and the West Virginia Supreme Court of Appeals decision in *Joseph Kubican v. The Tavern, LLC*, 232 W. Va. 268, 752 S.E.2d 299 (2013) be nullified.

(b) The failure of a limited liability company to observe the usual company formalities or requirements relating to the exercise of its company powers or management of its business is not a ground for imposing personal liability on the members or managers for liabilities of the company.

(c) All or specified members of a limited liability company are liable in their capacity as members for all or specified debts, obligations or liabilities of the company if:

~~(1) A provision to that effect is contained in the articles of organization; and~~

~~(2) A member so liable has consented in writing to the adoption of the provision or to be bound by the provision.~~

(1) A provision to that effect is contained in the articles of organization, and a member so liable has consented in writing to the adoption of the provision or to be bound by the provision;

(2) The member against whom liability is asserted has personally guaranteed the liability or obligation of the limited liability company in writing;

(3) As to a tax liability of the limited liability company, the law of the state or of the United States imposes liability upon the member;

(4) The member commits actual fraud which causes injury to an individual or entity.

(d) *Enterprise liability.* — In circumstances where the members of a limited liability company are, in whole or in part, corporations, limited liability companies, or other entities which are not human beings, then if a jury shall determine that the liability of a limited liability company sounding in tort arose as part of the activities of a joint enterprise, those entities which are part of the joint enterprise with the limited liability company may be liable for the liability of the limited liability company which arose as part of the business operations of the joint enterprise, not as a piercing of the veil, but instead under the doctrine of joint enterprise liability.

(e) *Member as tortfeasor.* — Nothing in this section shall immunize or shield a member of a limited liability company, solely because he or she is a member of a limited liability company, from

liability for his or her own tortious conduct that proximately causes injury to another party while the member is acting on behalf of the limited liability company. In such circumstance, the liability of a member is not through veil piercing, but rather primary, as against any tortfeasor.

(f) *Clawback authority.* — If a member is proved to have committed any of the following acts, then a creditor of the limited liability company whose judgment the limited liability company cannot satisfy may seek clawback from the member under this subsection: *Provided,* That the limited liability company's judgment creditor may proceed in the shoes of the limited liability company to clawback funds from the member in order to reimburse the limited liability company for either the amount of the judgment against the limited liability company or the amount transferred from the limited liability company to the member in bad faith, whichever is less. The wrongful acts which will justify clawback (but not veil piercing) are:

(1) Conflicted exchange;

(2) Insolvency distribution; or

(3) Siphoning of funds.

(g) *Definitions.* — As used in this section:

"Conflicted exchange" means a transfer of money or other property from a limited liability company to a member of the limited liability company (or to any other organization in which the member has a material financial interest) in exchange for services, goods, or other tangible or intangible property of less than reasonable equivalent value.

"Insolvency distribution" means a transfer of money or other property from a limited liability company to a member of that limited liability company (or to any other organization in which the member has a material financial interest), in respect of the member's ownership interest, that renders the limited liability company insolvent.

"Insolvent" means, with respect to a limited liability company, that the limited liability company is unable to pay its debts in the ordinary course of business. Claims that are unusual in nature or amount, including tort claims in claims for consequential damages, are not to be considered claims in the ordinary course of business for the purposes of this section.

"Siphoning of funds" means whether the manager or majority member has siphoned funds from the limited liability company in violation of the articles of organization, the operating agreement, or this article.

Following discussion,

At the request of Senator Trump, and by unanimous consent, Senator Trump's amendment to the bill (Com. Sub. for S. B. 258) was amended on page two, line twenty-five, section three hundred three, subsection (c), subdivision (3), after the word "member;" by inserting the word "or".

Following extended discussion,

The question being on the adoption of Senator Trump's amendment to the bill, as amended, the same was put and prevailed.

The bill (Com. Sub. for S. B. 258), as amended, was then ordered to engrossment and third reading.

Com. Sub. for Senate Bill 270, Streamlining process for utilities access to DOH rights-of-way.

On second reading, coming up in regular order, was reported by the Clerk.

At the request of Senator Takubo, unanimous consent being granted, the bill was laid over one day, retaining its place on the calendar.

Senate Bill 297, Extending expiration of military members' spouses' driver's license.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Com. Sub. for Senate Bill 390, Requiring electric utilities submit feasibility studies of constructing and operating middle-mile broadband internet projects.

On second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

Eng. House Bill 2351, Relating to regulating prior authorizations.

On second reading, coming up in regular order, was read a second time.

The following amendment to the bill, from the Committee on Health and Human Resources, was reported by the Clerk:

By striking out everything after the enacting clause and inserting in lieu thereof the following:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care: *Provided,* That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions may

be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient’s psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient’s medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to- peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided* That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care: *Provided*, That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy

has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to- peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not

less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided*, That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care: *Provided*, That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United

States Department of Health and Human Services (HHS). Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient’s psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to- peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided*, That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS, AND HEALTH SERVICE CORPORATIONS.

§33-24-7s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care; *Provided*, That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided*, That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care: *Provided*, That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient’s psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided*, That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

(1) Episode of Care means a specific medical problem, condition, or specific illness being managed across a continuum of care and includes tests and procedures initially requested, excluding out of network care: *Provided*, That any additional testing or procedures unrelated to the specific medical problem, condition, or specific illness being managed will required a separate prior authorization.

(2) National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by HHS;

(3) Prior Authorization means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b)The health insurers are required to develop prior authorization forms and portals and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on their webpage. The forms shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification confirming receipt of the prior authorization request if forms are submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated regularly to ensure that the list remains current;

(4) Inform the patient if the health insurers require plan members to use step therapy protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2019.

(c) The health insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health insurer is required to accept an electronically submitted prior authorization and may not require more than one prior authorization form for an episode of care. If the health insurers are currently accepting electronic prior authorization requests, they shall have until January 1, 2020, to implement the provisions of this section.

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the time on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months if the services are provided within the state.

(h) The health insurers shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests a peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this appeal process shall take no longer than 30 days.

(j) Any inpatient prescription written at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization must be obtained.

(k) If the approval of a prior authorization requires a medication substitution, the substituted medication must be of an equivalent medication class.

(l) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month time frame, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the results of the health insurer's internal audit.

(m) The health insurers must accept and respond to prior authorization requests for pharmacy benefits by July 1, 2020, or if the health insurers are currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The health insurers shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(o) The Department of Health and Human Services shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations pursuant to a contract with the department to provide medical services: *Provided* That the requirements in this subsection shall be expressly memorialized in such contract.

(p) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

On motion of Senator Maroney, the following amendments to the Health and Human Resources committee amendment to the bill (Eng. H. B. 2351) were reported by the Clerk, considered simultaneously, and adopted:

On page one, section seven-f, subsection (a), subdivision (1), after the words "or procedures" by inserting the words "related or";

On page one, section seven-f, subsection (a), subdivision (1), by striking out the word "required" and inserting in lieu thereof the word "require";

On page two, section seven-f, subsection (c), by striking out the word "they" and inserting in lieu thereof the words "the health insurers";

On page three, section seven-f, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page four, section seven-f, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page four, section seven-f, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

On page five, section seven-f, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”;

On page five, section four-s, subsection (a), subdivision (1), after the words “or procedures” by inserting the words “related or”;

On page five, section four-s, subsection (a), subdivision (1), by striking out the word “required” and inserting in lieu thereof the word “require”;

On page six, section four-s, subsection (c), by striking out the word “they” and inserting in lieu thereof the words “the health insurers”;

On page seven, section four-s, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page eight, section four-s, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page eight, section four-s, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

On page eight, section four-s, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”.

On page nine, section three-dd, subsection (a), subdivision (1), after the words “or procedures” by inserting the words “related or”;

On page nine, section three-dd, subsection (a), subdivision (1), by striking out the word “required” and inserting in lieu thereof the word “require”;

On page ten, section three-dd, subsection (c), by striking out the word “they” and inserting in lieu thereof the words “the health insurers”;

On page eleven, section three-dd, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page eleven, section three-dd, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page twelve, section three-dd, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

On page twelve, section three-dd, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”;

On page thirteen, section seven-s, subsection (a), subdivision (1), after the words “or procedures” by inserting the words “related or”;

On page thirteen, section seven-s, subsection (a), subdivision (1), by striking out the word “required” and inserting in lieu thereof the word “require”;

On page fourteen, section seven-s, subsection (c), by striking out the word “they” and inserting in lieu thereof the words “the health insurers”;

On page fifteen, section seven-s, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page fifteen, section seven-s, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page sixteen, section seven-s, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

On page sixteen, section seven-s, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”;

On page seventeen, section eight-p, subsection (a), subdivision (1), after the words “or procedures” by inserting the words “related or”;

On page seventeen, section eight-p, subsection (a), subdivision (1), by striking out the word “required” and inserting in lieu thereof the word “require”;

On page eighteen, section eight-p, subsection (c), by striking out the word “they” and inserting in lieu thereof the words “the health insurers”;

On page nineteen, section eight-p, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page nineteen, section eight-p, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page twenty, section eight-p, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

On page twenty, section eight-p, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”;

On page twenty-one, section eight-s, subsection (a), subdivision (1), after the words “or procedures” by inserting the words “related or”;

On page twenty-one, section eight-s, subsection (a), subdivision (1), by striking out the word “required” and inserting in lieu thereof the word “require”;

On page twenty-two, section eight-s, subsection (c), by striking out the word “they” and inserting in lieu thereof the words “the health insurers”;

On page twenty-two, section eight-s, subsection (e), after the words “two business days” by inserting the words “from the time on the electronic receipt of the prior authorization request”;

On page twenty-three, section eight-s, subsection (j), by striking out the words “Any inpatient prescription written” and inserting in lieu thereof the words “Any prescription written for an inpatient”;

On page twenty-four, section eight-s, subsection (m), after the words “must accept and respond to” by inserting the words “electronically submitted”;

And;

On page twenty-four, section eight-s, subsection (o), by striking out the word “Services” and inserting in lieu thereof the word “Resources”.

The question now being on the adoption of the Health and Human Resources committee amendment to the bill, as amended, the same was put and prevailed.

The bill (Eng. H. B. 2351), as amended, was then ordered to third reading.

The Senate proceeded to the tenth order of business.

Com. Sub. for Senate Bill 187, Authorizing Department of Revenue to promulgate legislative rules.

On first reading, coming up in regular order, was read a first time and ordered to second reading.

The Senate proceeded to the twelfth order of business.

Remarks were made by Senators Stollings, Rucker, Hardesty, and Maroney.

Thereafter, at the request of Senator Romano, and by unanimous consent, the remarks by Senators Stollings, Hardesty, and Maroney were ordered printed in the Appendix to the Journal.

Following a point of inquiry to the President, with resultant response thereto,

Remarks were made by Senator Maynard.

At the request of Senator Takubo, unanimous consent being granted, a leave of absence for the day was granted Senator Boley.

Pending announcement of meetings of standing committees of the Senate, including a meeting of the Committee of the Whole,

On motion of Senator Takubo, at 1:12 p.m., the Senate adjourned until tomorrow, Wednesday, January 30, 2019, at 9:30 a.m.

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SENATE CALENDAR

Wednesday, January 30, 2019
9:30 AM

THIRD READING

Com. Sub. for S. B. 4 - Relating generally to Municipal Home Rule Program - (With right to amend)

Eng. Com. Sub. for S. B. 72 - Creating Sexual Assault Victims' Bill of Rights

Eng. Com. Sub. for S. B. 102 - Relating generally to powers and authority of courthouse security officers

Eng. S. B. 149 - Exempting certain veterans from concealed weapons license fees (original similar to HB2672)

Eng. Com. Sub. for S. B. 199 - Authorizing certain miscellaneous agencies and boards promulgate legislative rules (original similar to HB2282)

Eng. S. B. 233 - Relating to age requirements for deputy sheriff

Eng. Com. Sub. for S. B. 243 - Requiring racetrack participate in WV Thoroughbred Development Fund

Eng. S. B. 256 - Allowing certain deductions from individual personal income tax refunds

Eng. Com. Sub. for S. B. 258 - Establishing common law "veil piercing" claims not be used to impose personal liability

Eng. S. B. 297 - Extending expiration of military members' spouses' driver's license

Eng. Com. Sub. for S. B. 390 - Requiring electric utilities submit feasibility studies of constructing and operating middle-mile broadband internet projects

Eng. H. B. 2351 - Relating to regulating prior authorizations

SECOND READING

Com. Sub. for S. B. 187 - Authorizing Department of Revenue to promulgate legislative rules (original similar to HB2270)

Com. Sub. for S. B. 270 - Streamlining process for utilities access to DOH rights-of-way (original similar to HB2416)

FIRST READING

Com. Sub. for S. B. 103 - Relating generally to Public Defender Services

Com. Sub. for S. B. 264 - Requiring courts to order restitution to crime victims where economically practicable

S. B. 331 - Using leashed dogs to track mortally wounded deer or bear

S. B. 332 - Relating to Class Q special hunting permit for disabled persons

ANNOUNCED SENATE COMMITTEE MEETINGS

Regular Session 2019

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Wednesday, January 30, 2019

11 a.m.	Committee of the Whole	(Senate Chamber)
2 p.m.	Agriculture & Rural Development	(Room 208W)