WEST VIRGINIA LEGISLATURE

SENATE JOURNAL

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

Charleston, West Virginia, Friday, February 8, 2019

The Senate met at 11:14 a.m.

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

Prayer was offered by the Reverend Jim Walther, Jr., Interim Pastor, First Presbyterian Church of Nitro, Nitro, West Virginia.

The Senate was then led in recitation of the Pledge of Allegiance by the Honorable Michael J. Romano, a senator from the twelfth district.

Pending the reading of the Journal of Thursday, February 7, 2019,

At the request of Senator Boso, 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 concurrence by that body in the passage, to take effect from passage, of

Eng. Senate Bill 324, Relating to Commissioner of Agriculture employees.

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 2204—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §30-1-22, relating to prohibiting state licensing boards from hiring lobbyists; and declaring that the director, board counsel and appointed board members of each board may lobby on behalf of the board.

Referred to the Committee on Government Organization.

A message from the Clerk of the House of Delegates announced the concurrence by that body in the Senate amendments, as amended by the House of Delegates, passage as amended, and requested the concurrence of the Senate in the House of Delegates amendments to the Senate amendments, as to

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

On motion of Senator Takubo, the bill was taken up for immediate consideration.

The following House of Delegates amendments to the Senate amendments to the bill were reported by the Clerk:

By striking out everything after the enacting section 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by health care practitioner, to be performed at, the site of service, excluding out of network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

"Prior Authorization" means obtaining advance approval from the Public Employees Insurance Agency about the coverage of a service or medication.

(b) The Public Employees Insurance Agency is 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 the Public Employees Insurance Agency's 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 Public Employees Insurance Agency requires a prior authorization. This list shall 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 at least quarterly to ensure that the list remains current;

(4) Inform the patient if the Public Employees Insurance Agency requires a plan member 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 Public Employees Insurance Agency 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 Public Employees Insurance Agency shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The Public Employees Insurance Agency 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 Public Employees Insurance Agency is currently accepting electronic prior authorization requests, the Public Employees Insurance Agency 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 Public Employees Insurance Agency 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 Public Employees Insurance Agency 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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the Public Employees Insurance Agency shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the Public Employees Insurance Agency 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 the Public Employees Insurance Agency is carried over to all other managed care organizations and health insurers for three months, if the services are provided within the state.

(h) The Public Employees Insurance Agency shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Public Employees Insurance Agency and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The Public Employees Insurance Agency'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) (1) Any prescription written for an inpatient 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 health care practitioner 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 Public Employees Insurance Agency 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 shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines the health care practitioner is not performing the procedure in conformity with the Public Employees Insurance Agency's benefit plan based upon the results of the Public Employees Insurance Agency's internal audit.

(l) The Public Employees Insurance Agency must accept and respond to electronically submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the Public Employees Insurance Agency is currently accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement this provision. The Public Employees Insurance Agency shall accept and respond to prior authorizations though a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

(m) 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.

(n) 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by health care practitioner, to be performed at the site of service, excluding out of network care: *Provided,* That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

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

(b) The health insurer is 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 its' 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 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 insurer requires a plan member 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 insurer 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 insurer is currently accepting electronic prior authorization requests, the health insurer 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 health care practitioner with knowledge of the patient's medical would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care 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 health insurer is carried over to all other managed care organizations, health insurers and the, Public Employees Insurance Agency for three months, if the services are provided within the state.

(h) The health insurer 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 an appeal by 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) (1) Any prescription written for an inpatient 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health insurer 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.

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

(m) 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.

(n) 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

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

(b) The health insurer is 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 the health insurer's 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 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 at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member 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 insurer 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 insurer is currently accepting electronic prior authorization requests, the health insurer 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 condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care 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 insurer 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 an appeal by 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) (1) Any prescription written for an inpatient 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 shall 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.

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

(m) 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.

(n) 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by health care practitioner, to be performed at the site of service, excluding out of network care: *Provided,* That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

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

(b) The health insurer is 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 health insurer's 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 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 at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member 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 insurer 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 insurer is currently accepting electronic prior authorization requests, the health insurer 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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care 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 health insurer is carried over to all other managed care organizations and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer 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 an appeal by 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) (1) Any prescription written for an inpatient 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health insurer 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.

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

(m) 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.

(n) 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, ~~and~~ procedures and rehabilitation initially requested by health care practitioner, to be performed at the site of service, excluding out of network care: *Provided,* That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

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

(b) The health insurer is 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 health insurer's 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 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 at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member 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 insurer 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 insurer is currently accepting electronic prior authorization requests, the health insurer 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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care 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 health insurer is carried over to all other managed care organizations and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer 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 an appeal by 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) (1) Any prescription written for an inpatient 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health insurer 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.

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

(m) 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.

(n) 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:

"Episode of Care" means a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by health care practitioner, to be performed at the site of service, excluding out of network care: *Provided,* That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

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

"Prior Authorization" means obtaining advance approval from a health maintenance organization about the coverage of a service or medication.

(b) The health maintenance organization is 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 health maintenance organization's 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 maintenance organization 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 at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health maintenance organization require a plan member 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 maintenance organization 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 maintenance organization shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The health maintenance organization 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 maintenance organization is currently accepting electronic prior authorization requests, the health maintenance organization 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 maintenance organization 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 maintenance organization 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 health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health maintenance organization shall identify all deficiencies and within two business days from the time on the electronic receipt of the prior authorization request 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 return request is received by the health care practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) If the health maintenance organization 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 health maintenance organization is carried over to all other managed care organizations, health insurers and the Public Employees Insurance Agency for three months if the services are provided within the state.

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

(i) If a prior authorization is rejected by the health maintenance organization and the health care practitioner who submitted the prior authorization requests an appeal by 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 maintenance organization'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) (1) Any prescription written for an inpatient 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.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 et seq.

(k) 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 maintenance organization 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 shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health maintenance organization and may be rescinded if the health maintenance organization determines the health care practitioner is not performing the procedure in conformity with the health maintenance organization's benefit plan based upon the results of the health maintenance organization's internal audit.

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

(m) 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.

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

And,

By striking out the title and substituting therefor a new title, to read as follows:

Eng. House Bill 2351—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §5-16-7f; to amend said code by adding thereto a new section, designated §33-15-4s; to amend said code by adding thereto a new section, designated §33-16-3dd; to amend said code by adding thereto a new section, designated §33-24-7s; to amend said code by adding thereto a new section, designated §33-25-8p; and to amend said code by adding thereto a new section, designated §33-25A-8s, all relating to prior authorizations; requiring health insurers to develop prior authorization forms; requiring health insurers to develop prior authorization portals; defining terms; providing for electronically transmitted prior authorization forms; establishing procedures for submission and acceptance of forms; establishing form requirements; establishing deadlines for approval of prior authorizations; providing for a process of an incomplete prior authorization submission; providing for an audit; setting forth peer review procedures; requiring health insurers to accept a prior authorization from other health insurers for a period of time; requiring health insurers to use certain standards when reviewing a prior authorization; providing an exemption for medication provide upon discharge; requiring an exemption for health care practitioners meeting specified criteria; requiring certain information to be included on the health insurer's web page; establishing deadlines for pharmacy benefit prior authorization; establishing submission format for pharmacy benefits; setting forth an effective date; providing for implementation applicability; and setting deadlines.

On motion of Senator Takubo, the Senate refused to concur in the foregoing House amendments to the bill (Eng. H. B. 2351) and requested the House of Delegates to recede therefrom.

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

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 2479—A Bill to amend and reenact §33-33-2, §33-33-12 and §33-33-16 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-33-12a; and to amend said code by adding thereto a new article, designated §33-52-1, §33-52-2, §33-52-3, §33-52-4, §33-52-5, §33-52-6, §33-52-7, §33-52-8, and §33-52-9, all relating to the corporate governance practices of an insurance company or a group of insurers; defining internal audit function; making an insurer's audit committee responsible for overseeing the insurer's internal audit function; providing that certain insurers must establish an internal audit function with respect to the insurer's governance, risk management, and internal controls; requiring the head of an insurer's internal audit function to report to the insurer's audit committee regularly, but no less than annually, about the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings; exempting certain insurers from the internal audit function requirements; stating purpose of Corporate Governance Annual Disclosure Act; defining terms; requiring an insurer to annually submit to the insurance commissioner a corporate governance annual disclosure; describing the contents of the corporate governance annual disclosure; requiring that the corporate governance annual disclosure include a signature of the insurer's chief executive officer or corporate secretary; permitting the insurer to choose the corporate level that the corporate governance annual disclosure is applicable, depending upon how the insurer has structured its corporate governance system; allowing the insurer to comply with the corporate governance annual disclosure requirements by cross referencing other documents or referencing documents already in the possession of the insurance commissioner; requiring that documents and other information related to the corporate governance annual disclosure be confidential and privileged; permitting the insurance commissioner to share documents, materials or other corporate governance annual disclosure-related information with National Association of Insurance Commissioners and other regulatory bodies; providing that the insurance commissioner may retain third-party consultants to assist the commissioner in reviewing the corporate governance annual disclosure and related information; subjecting such third-party consultants and the National Association of Insurance Commissioners to the same confidentiality standards as the insurance commissioner; setting forth the penalty for an insurer that fails to timely provide a corporate governance annual disclosure to the insurance commissioner; and providing for effective dates.

Referred to the Committee on the Judiciary.

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

Eng. Com. Sub. for House Bill 2481—A Bill to amend and reenact §60-3A-18 of the Code of West Virginia, 1931, as amended, relating to permitting retail liquor licensees to sell certain alcoholic beverages after 1 p.m. on Sundays.

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. House Bill 2608—A Bill to repeal §61-3-39l of the Code of West Virginia, 1931, as amended, relating to requiring printing the date a consumer deposit account was opened on paper check.

Referred to the Committee on Banking and Insurance.

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 2686—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §62-15B-1, and §62-15B-2, all relating to permitting the Supreme Court of Appeals of West Virginia to create a family drug treatment court pilot program; permitting the implementation of a family drug treatment court pilot program in at least four circuits; restricting family drug treatment courts to individuals with substance use disorders who are involved in a child abuse and neglect case; permitting the Supreme Court of Appeals of West Virginia to provide oversight, technical assistance and training; establishing a state family drug treatment court advisory committee; establishing a local family drug treatment court advisory committee; requiring each local family drug treatment court advisory committee to establish criteria for the eligibility and participation of adult responders who have been adjudicated an abusing or neglecting parent and who have been granted a post-adjudicatory improvement period and who have a substance use disorder; prohibiting certain respondents from being eligible for participation in a family drug treatment court; and providing that participation by an adult respondent in a family drug treatment court shall be voluntary and made pursuant only to a written agreement by and between the adult respondent and the department with concurrence of the court.

Referred to the Committee on the Judiciary.

The Senate proceeded to the fourth order of business.

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 40, Establishing Military Service Members Court program.

Senate Bill 47, Providing wind power projects be taxed at real property rate.

Senate Bill 296, Providing 11-month window to permit members of PERS to purchase credited service.

And,

Senate Bill 461, Providing for personal income tax withholding on certain lottery winnings.

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

Respectfully submitted,

Craig Blair,
Chair.

Senator Boso, from the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration

Com. Sub. for Senate Bill 285 (originating in the Committee on Agriculture and Rural Development), Relating to modification of cottage food laws.

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

Com. Sub. for Com. Sub. for Senate Bill 285 (originating in the Committee on Government Organization)—A Bill to amend and reenact §19-35-2 of the Code of West Virginia, 1931, as amended, and to amend said code by adding thereto a new section, designated §19-35-6, all relating to the sale of homemade food items; defining terms; authorizing production and sale of homemade food items under certain circumstances; establishing conditions for exemption from licensure, permitting, inspection, packaging, and labeling laws; providing required notices to consumer; defining manner of providing notices; exempting certain products from the scope of this provision; permitting local health departments to inspect reported foodborne illnesses; authorizing Department of Agriculture to provide assistance, consultation, or inspection at request of producer; providing for preemption by county, local and municipal ordinances; and identifying certain laws and regulations from which this section does not provide exemption.

With the recommendation that the committee substitute for committee substitute do pass.

Respectfully submitted,

Gregory L. Boso,
Chair.

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

Your Committee on Finance has had under consideration

Senate Bill 291, Relating generally to survivor benefits for emergency response providers.

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

Com. Sub. for Senate Bill 291 (originating in the Committee on Finance)—A Bill to amend and reenact §5H-1-1, §5H-1-2, and §5H-1-3 of the Code of West Virginia, 1931, as amended, all relating generally to survivor benefits for emergency response providers; changing the name of the West Virginia Fire and EMS Survivor Benefit Act to the West Virginia Emergency Responders Survivor Benefit Act; making Division of Forestry personnel who die as a proximate result of their participation in wildland fire fighting, emergency response, or disaster response operations eligible for survivor benefits; defining terms; making technical changes; and reorganizing language in the act for clarity.

With the recommendation that the committee substitute do pass.

Respectfully submitted,

Craig Blair,
Chair.

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 305, Prohibiting waste of big game animals.

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

Respectfully submitted,

Mark R. Maynard,
Chair.

The bill, under the original double committee reference, was then referred to the Committee on the Judiciary.

Senator Boso, from the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration

Senate Bill 345, Adding definition of “grantee” to include state spending units and local governments.

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

Com. Sub. for Senate Bill 345 (originating in the Committee on Government Organization)—A Bill to amend §8-15-8b of the Code of West Virginia, 1931, as amended, to amend and reenact §12-4-14 of said code; to amend said code by adding thereto a new section, designated §12-4-14b, and to amend and reenact §29-3-5f of said code, all relating to fire service equipment and training funds for volunteer and part-volunteer fire companies and departments; authorizing fire departments to file bank statements and check images instead of sworn statements of expenditures; prohibiting the commingling of funds; requiring retention of payment records; defining terms; changing deadline dates; authorizing forfeiture and redistribution of funds of delinquent fire departments; prohibiting the conversion of funds through returns or refunds of goods or services; providing for deductions from quarterly distributions to offset improper expenditures by a fire company or department; clarifying the responsibility for proposing legislative rules; requiring written notifications of delinquencies and misapplications of funds; providing a procedure to contest findings of Legislative Auditor; removing certain criminal penalties; and updating outdated language.

With the recommendation that the committee substitute do pass.

Respectfully submitted,

Gregory L. Boso,
Chair.

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 402, Authorizing Division of Forestry investigate and enforce timber theft violations.

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

Com. Sub. for Senate Bill 402 (originating in the Committee on Natural Resources)—A Bill to amend and reenact §19-1A-3b of the Code of West Virginia, 1931, as amended, relating to authorizing the Division of Forestry to investigate and enforce timber theft violations on all lands and directing the penalties for timber theft to the criminal statute.

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

Respectfully submitted,

Mark R. Maynard,
Chair.

The bill (Com. Sub. for S. B. 402), under the original double committee reference, was then referred to the Committee on the Judiciary.

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 404, Altering sediment control during commercial timber harvesting operations.

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

Com. Sub. for Senate Bill 404 (originating in the Committee on Natural Resources)—A Bill to amend and reenact §19-1B-4, §19-1B-6, §19-1B-7, §19-1B-10, and §19-1B-12a of the Code of West Virginia, 1931, as amended, all relating generally to sediment control during commercial timber harvesting operations; increasing the threshold amount before a logger must follow certain licensing requirements regarding sediment control; requiring the logger to notify the Director of the Division of Forestry at least three days before timbering begins; requiring certain training requirements prior to recertification of certified loggers; providing for appeals; increasing criminal penalties; and editing certain limitations on issuing citations and powers of arrest.

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

Respectfully submitted,

Mark R. Maynard,
Chair.

The bill (Com. Sub. for S. B. 404), under the original double committee reference, was then referred to the Committee on Government Organization.

Senator Boso, from the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration

Senate Bill 405, Increasing limit on additional expenses incurred in preparing notice list for redemption.

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

Com. Sub. for Senate Bill 405 (originating in the Committee on Government Organization)—A Bill to amend and reenact §11A-3-23, §11A-3-25, §11A-3-36, §11A-3-56, §11A-3-57, and §11A-3-58 of the Code of West Virginia, 1931, as amended, relating to the sale of tax liens by the State Auditor; increasing the limit to $500 on additional expenses a purchaser may recover in preparing notice list for redemption of purchase and for licensed attorney's title examination; and requiring any amounts above the surplus of 20 percent of the gross amount of the operating fund be paid to the general school fund at the end of each fiscal year.

With the recommendation that the committee substitute do pass.

Respectfully submitted,

Gregory L. Boso,
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 481, Relating to Judicial Vacancy Advisory Commission.

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

Com. Sub. for Senate Bill 481 (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, relating to the Judicial Vacancy Advisory Commission; altering the in-state residency requirements for members of the commission; providing that no more than four of its appointed members may be residents of the same congressional district; providing that no more than two of its appointed members may be residents of the same state senatorial district; clarifying that current commission members will not be disqualified from serving for the remainder of their terms based on amendments to in-state residency requirements; and deleting obsolete language.

With the recommendation that the committee substitute do pass.

Respectfully submitted,

Charles S. Trump IV,
Chair.

Senator Maroney, from the Committee on Health and Human Resources, submitted the following report, which was received:

Your Committee on Health and Human Resources has had under consideration

Senate Bill 518, Restricting sale and trade of dextromethorphan.

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

Respectfully submitted,

Michael J. Maroney,
Chair.

The bill, under the original double committee reference, was then referred to the Committee on the Judiciary.

Senator Maroney, from the Committee on Health and Human Resources, submitted the following report, which was received:

Your Committee on Health and Human Resources has had under consideration

Senate Bill 519, Requiring county emergency dispatchers complete course for telephonic cardiopulmonary resuscitation.

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

Respectfully submitted,

Michael J. Maroney,
Chair.

The bill, under the original double committee reference, was then referred to the Committee on Finance.

Senator Boso, from the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration

Eng. Com. Sub. for House Bill 2446, Blue Alert Plan.

And reports the same back with the recommendation that it do pass.

Respectfully submitted,

Gregory L. Boso,
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 Rucker, Blair, Trump, Unger, and Boso:

Senate Bill 555—A Bill to amend and reenact §18B-5-3 of the Code of West Virginia, 1931, as amended, relating to the authority of the Higher Education Policy Commission, the Council for Community and Technical College Education, and institutional governing boards to enter into contracts for programs, services, and facilities; and providing for specified flexibility entering into agreements with certain affiliated nonprofit corporations.

Referred to the Committee on Government Organization.

By Senators Tarr, Azinger, Maynard, Smith, Boso, Cline, and Swope:

Senate Bill 556—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §62-15B-1, §62-15B-2, §62-15B-3, §62-15B-4, and §62-15B-5, all relating to limiting the liability of employers in cases where convictions for certain crimes are expunged; requiring creation of a database record showing offenses were expunged; requiring courts to cross-reference database for expungements; providing that an employer is not liable to furnish health insurance or health care costs to persons whose records are expunged for drug addiction related offenses or drug addiction related diseases; and providing exceptions.

Referred to the Committee on the Judiciary.

By Senators Sypolt, Cline, and Boso:

Senate Bill 557—A Bill to amend and reenact §7-11B-14 of the Code of West Virginia, 1931, as amended; and to amend and reenact §8-12-5 of said code, all relating to allowing municipalities to contract, without bidding, projects up to $50,000.

Referred to the Committee on Government Organization.

By Senator Azinger:

Senate Bill 558—A Bill to amend and reenact §3-7-6 of the Code of West Virginia, 1931, as amended, relating to requiring state and federal elections to be contested before the next election.

Referred to the Committee on the Judiciary.

By Senators Stollings, Takubo, Plymale, Baldwin, Lindsay, Jeffries, Hardesty, and Prezioso:

Senate Bill 559—A Bill to amend and reenact §5-16B-6d of the Code of West Virginia, 1931, as amended; and to amend and reenact §9-5-12 of said code, all relating to expanding comprehensive coverage for pregnant women through Medicaid to 185 percent of the federal poverty level; providing coverage for 60 days postpartum; expanding comprehensive coverage for pregnant women between 185 percent and 300 percent of the federal poverty level including

prenatal care, delivery, and 60 days postpartum through the Children's Health Insurance Program.

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

By Senators Stollings, Takubo, Lindsay, Hardesty, and Prezioso:

Senate Bill 560—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §5-16-8b; to amend said code by adding thereto a new section, designated §33-15-4s; to amend said code by adding thereto a new section, designated §33-16-3dd; to amend said code by adding thereto a new section, designated §33-24-7s; to amend said code by adding thereto a new section, designated §33-25-8p; and to amend said code by adding thereto a new section, designated §33-25A-8s, all relating to prohibiting insurance coverage from requiring prior authorization for physician prescribed tests to stage cancer.

Referred to the Committee on Health and Human Resources.

By Senators Trump, Takubo, and Boso:

Senate Bill 561—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §60-2-17a; to amend and reenact §60-6-7, §60-6-8, and §60-6-9 of said code; to amend and reenact §60-7-2, §60-7-3, §60-7-4, §60-7-5, §60-7-6, and §60-7-12 of said code; to amend said code by adding thereto two new sections, designated §60-7-6a and §60-7-8a; and to amend and reenact §61-8-27 of said code, all relating to permitting the Alcohol Beverage Control Administration to request the assistance of law enforcement; clarifying that consumption of alcoholic liquors in public is unlawful; clarifying that West Virginia licensees can only sell liquor by the drink; clarifying certain licensing requirements for licensure; clarifying prohibition on liquor bottle sales in Class A licenses; providing guidance on certain lawful conduct such as wine bottle sales and frozen drink machines; creating a private fair and festival license; definitions; license requirements; license fee; creating the private hotel license and license fee; creating a private nine-hole golf course license and fee; definitions; license requirements; license fee; permitting a private resort hotel to have inner-connection with a resident brewer who has a brewpub; providing a 30-day requirement to issue or deny a completed license application; creating a reactivation fee for licensees who fail to timely file their renewal application and pay their annual license fees; permitting a license privilege for certain licensees to operate a connected but separately operated Class A on-premises license and a Class B off-premises license; clarifying that certain state licensed gaming is permissible in a private club; and permitting minors to attend a private nine-hole golf course and a private fair or festival under certain conditions.

Referred to the Committee on the Judiciary.

By Senators Clements, Beach, Boso, and Cline:

Senate Bill 562—A Bill to repeal §29-2A-9, §29-2A-10, §29-2A-11, §29-2A-11a, §29-2A-11b, §29-2A-11c, §29-2A-11d, §29-2A-11e, §29-2A-11f, §29-2A-12, §29-2A-13, §29-2A-14, §29-2A-17, §29-2A-18, §29-2A-19, §29-2A-20, §29-2A-21, §29-2A-22, §29-2A-23, §29-2A-24, §29-2A-25, §29-2A-26, §29-2A-27, and §29-2A-28 of the Code of West Virginia, 1931, as amended; and to amend and reenact §29-2A-1, §29-2A-2, §29-2A-3, §29-2A-4, §29-2A-5, §29-2A-6, §29-2A-7, and §29-2A-8 of said code, all relating to the State Aeronautics Commission; removing antiquated and inoperable provisions and sections; modifying and deleting definitions; continuing the State Aeronautics Commission; modifying and updating membership requirements, powers, and duties of the commission; setting forth quorum and meeting requirements; providing for the organization

and operation of the commission; modifying provisions related to the director of the commission; updating provisions related to funding and federal aid; and continuing general powers related to planning, establishing, constructing, maintaining, and operating of airports.

Referred to the Committee on Government Organization.

By Senators Trump, Woelfel, Plymale, Boso, and Rucker:

Senate Bill 563—A Bill to amend and reenact §61-8B-11 of the Code of West Virginia, 1931, as amended, relating generally to evidence in prosecution for sexual offenses; prohibiting a victim from being subjected to certain physical examinations; and providing that a victim's refusal to undergo certain physical examinations does not preclude admission of evidence regarding other physical examinations.

Referred to the Committee on the Judiciary.

Senators Swope, Jeffries, Plymale, Beach, Lindsay, Stollings, Boso, and Maynard offered the following resolution:

Senate Concurrent Resolution 26—Requesting the Division of Highways name Bridge Number 28-19-31.63 (28A066), locally known as Flat Top Overpass Bridge No. 1, carrying US 19 over Interstate 77 in Mercer County, the "Thompson-Lambert Memorial Bridge".

Whereas, Tragedy befell Mercer County on August 16, 2018, when the vehicles of three employees of the West Virginia Parkways Authority's Courtesy Patrol were struck while on duty by a tractor-trailer at mile marker 23 on the West Virginia Turnpike; and

Whereas, Emergency responders pronounced Nathan Thompson, 32, of Princeton, dead at the scene. Mr. Thompson's nephew, Richard Lambert, 21, of Kegley, died at a Roanoke, Virginia, hospital on the following day. The third victim, Ethan Kestner, 19, also of Princeton, is still recovering from his injuries; and

Whereas, All three young men were known to be good employees of the turnpike authority, as well as decent, law-abiding citizens. Mr. Thompson and Mr. Lambert were both known as beloved family members. Since the time of the tragic accident, the entire Mercer County community has been saddened by the loss of the two young men and united in its thoughts and prayers for the recovery of Mr. Kestner; and

Whereas, All three young men are a special fraternity of employees who are partners in public service. Many public servants toil in often dangerous situations. While they take extraordinary precautions to ensure the safety of themselves and the public they serve, there is always an element of potential danger inherent in any occupation that must be performed in close proximity to large, heavy, fast-moving vehicles; and

Whereas, Partners in public service hope to return home to their families at the end of each duty assignment. When that does not happen, the sadness that ensues is shared by more than just their families and friends; and

Whereas, It is fitting that an enduring memorial be established to commemorate Nathan Thompson and Richard Lambert; therefore, be it

Resolved by the Legislature of West Virginia:

That the Division of Highways is hereby requested to name bridge number 28-19-31.63 (28A066), locally known as Flat Top Overpass Bridge No. 1, carrying US 19 over Interstate 77 in Mercer County, the “Thompson-Lambert Memorial Bridge”; and, be it

Further Resolved, That the Division of Highways is hereby requested to have made and be placed signed identifying the bridge as the “Thompson-Lambert Memorial Bridge”; and, be it

Further Resolved, That the Clerk of the Senate is hereby directed to forward a copy of this resolution to the Commissioner of the Division of Highways.

Which, under the rules, lies over one day.

The Senate proceeded to the eighth order of business.

Eng. Senate Bill 16, Authorizing expenditure of surplus funds by Wyoming County Commission.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. S. B. 16) passed with its title.

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

Eng. Com. Sub. for Senate Bill 30, Eliminating tax on annuity considerations collected by life insurer.

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 Committee Substitute for Senate Bill 30 pass?”

On the passage of the bill, the yeas were: Azinger, Baldwin, Beach, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

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. 30) passed with its title.

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

Eng. Com. Sub. for Com. Sub. for Senate Bill 90, Transferring Safety and Treatment Program from DHHR to DMV.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. Com. Sub. for Com. Sub. for S. B. 90) passed with its title.

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

Eng. Com. Sub. for Senate Bill 237, Improving ability of law enforcement to locate and return missing persons.

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 Committee Substitute for Senate Bill 237 pass?”

On the passage of the bill, the yeas were: Azinger, Baldwin, Beach, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

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. 237) passed with its title.

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

Eng. Com. Sub. for Senate Bill 263, Limiting number of days legislators may be compensated during extended and extraordinary sessions if budget bill not enacted.

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 Committee Substitute for Senate Bill 263 pass?”

On the passage of the bill, the yeas were: Azinger, Baldwin, Beach, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

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. 263) passed with its title.

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

Eng. Com. Sub. for Senate Bill 323, Establishing revenue fund and source to support Department of Agriculture’s improvement to facilities.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

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. 323) passed with its title.

Senator Takubo moved that the bill take effect from passage.

On this question, the yeas were: Azinger, Baldwin, Beach, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, two thirds of all the members elected to the Senate having voted in the affirmative, the President declared the bill (Eng. Com. Sub. for S. B. 323) takes effect from passage.

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

Eng. Senate Bill 343, Relating to review and approval of state property leases.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. S. B. 343) passed with its title.

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

Eng. Senate Bill 346, Changing rate which certain judges are paid for mileage when traveling within state.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. S. B. 346) passed with its title.

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

Eng. Com. Sub. for Senate Bill 356, Requiring MAPS provide state and federal prosecutors information.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

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. 356) passed with its title.

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

Eng. Senate Bill 453, Relating to background checks of certain financial institutions.

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, Boley, Boso, Clements, Cline, Facemire, Hamilton, Hardesty, Ihlenfeld, Jeffries, Lindsay, Maynard, Plymale, Prezioso, Roberts, Romano, Rucker, Smith, Stollings, Swope, Sypolt, Takubo, Tarr, Trump, Unger, Weld, Woelfel, and Carmichael (Mr. President)—30.

The nays were: None.

Absent: Blair, Mann, Maroney, and Palumbo—4.

So, a majority of all the members present and voting having voted in the affirmative, the President declared the bill (Eng. S. B. 453) 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 13, Relating to distributions from State Excess Lottery Fund.

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.

Com. Sub. for Com. Sub. for Senate Bill 14, Creating WV Farm-to-School Grant Program.

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 19, Relating to Senior Farmers Market Nutrition Program.

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

Com. Sub. for Com. Sub. for Senate Bill 317, Authorizing three or more adjacent counties form multicounty trail network authority.

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 352, Relating to Division of Corrections and Rehabilitation acquiring and disposing of services, goods, and commodities.

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 408, Determining indigency for public defender services.

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 496, Transferring authority to regulate milk from DHHR to Department of Agriculture.

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

On motion of Senator Sypolt, the following amendment to the bill was reported by the Clerk and adopted:

On page six, section five, lines five and six, by striking out the following: Applications for licensure shall be accompanied by a fee prescribed by the commissioner.

The bill (Com. Sub. for S. B. 496), as amended, was then ordered to third reading.

Senate Bill 499, Amending WV tax laws to conform to changes in partnerships for federal income tax purposes.

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

Senate Bill 542, Relating to registration fees for military-related special registration plates.

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

Com. Sub. for Senate Joint Resolution 5, Clarification of the Judiciary's Role in Impeachment Proceedings Amendment.

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

Eng. Com. Sub. for House Bill 2191, Relating generally to limited video lottery.

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

Eng. Com. Sub. for House Bill 2307, Relating to creating a provisional license for practicing barbering and cosmetology.

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

The Senate proceeded to the tenth order of business.

At the request of Senator Takubo, unanimous consent being granted, the following bills on first reading were considered read a first time and ordered to second reading:

Com. Sub. for Senate Bill 26, Permitting certain employees of educational service cooperatives participate in state's teacher retirement systems.

Senate Bill 153, Providing greater flexibility for making infrastructure project grants.

Senate Bill 440, Relating to Antihazing Law.

Senate Bill 442, Supplementing, amending, and decreasing appropriation to Insurance Commission.

Senate Bill 443, Supplemental appropriation of federal moneys to DHHR divisions.

Senate Bill 444, Supplemental appropriation to DHHR divisions.

Senate Bill 452, Supplemental appropriation to Second Chance Driver's License Program.

Com. Sub. for Senate Bill 491, Extending effective date for voter registration in conjunction with driver licensing.

Eng. House Bill 2459, Exercising authority to exempt individuals domiciled within the state from certain restrictions contained in federal law.

Eng. House Bill 2492, Relating to mandatory reporting procedures of abuse and neglect of adults and children.

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

On motion of Senator Takubo, at 11:59 a.m., the Senate adjourned until Monday, February 11, 2019, at 11 a.m.

SENATE CALENDAR

Monday, February 11, 2019
11:00 AM

UNFINISHED BUSINESS

S. C. R. 26 - Thompson-Lambert Memorial Bridge

THIRD READING

Eng. Com. Sub. for Com. Sub. for S. B. 14 - Creating WV Farm-to-School Grant Program

Eng. Com. Sub. for S. B. 19 - Relating to Senior Farmers Market Nutrition Program

Eng. Com. Sub. for Com. Sub. for S. B. 317 - Authorizing three or more adjacent counties form multicounty trail network authority

Eng. Com. Sub. for S. B. 352 - Relating to Division of Corrections and Rehabilitation acquiring and disposing of services, goods, and commodities (original similar to HB2772)

Eng. Com. Sub. for S. B. 408 - Determining indigency for public defender services

Eng. Com. Sub. for S. B. 496 - Transferring authority to regulate milk from DHHR to Department of Agriculture

Eng. S. B. 499 - Amending WV tax laws to conform to changes in partnerships for federal income tax purposes

Eng. S. B. 542 - Relating to registration fees for military-related special registration plates

Eng. Com. Sub. for S. J. R. 5 - Clarification of the Judiciary's Role in Impeachment Proceedings Amendment

Eng. Com. Sub. for H. B. 2191 - Relating generally to limited video lottery

Eng. Com. Sub. for H. B. 2307 - Relating to creating a provisional license for practicing barbering and cosmetology

SECOND READING

Com. Sub. for S. B. 13 - Relating to distributions from State Excess Lottery Fund

Com. Sub. for S. B. 26 - Permitting certain employees of educational service cooperatives participate in state's teacher retirement systems (original similar to HB2780)

S. B. 153 - Providing greater flexibility for making infrastructure project grants

S. B. 440 - Relating to Antihazing Law

S. B. 442 - Supplementing, amending, and decreasing appropriation to Insurance Commission (original similar to HB2795)

S. B. 443 - Supplemental appropriation of federal moneys to DHHR divisions (original similar to HB2782)

S. B. 444 - Supplemental appropriation to DHHR divisions

S. B. 452 - Supplemental appropriation to Second Chance Driver's License Program (original similar to HB2783)

Com. Sub. for S. B. 491 - Extending effective date for voter registration in conjunction with driver licensing

Eng. H. B. 2459 - Exercising authority to exempt individuals domiciled within the state from certain restrictions contained in federal law - (Com. title amend. pending)

Eng. H. B. 2492 - Relating to mandatory reporting procedures of abuse and neglect of adults and children - (Com. amend. pending)

FIRST READING

Com. Sub. for S. B. 40 - Establishing Military Service Members Court program

S. B. 47 - Providing wind power projects be taxed at real property rate

Com. Sub. for Com. Sub. for S. B. 285 - Relating to sale of homemade food items (original similar to HB2564)

Com. Sub. for S. B. 291 - Relating generally to survivor benefits for emergency response providers (original similar to HB2438)

S. B. 296 - Providing 11-month window to permit members of PERS to purchase credited service

Com. Sub. for S. B. 345 - Relating to fire service equipment and training funds for VFDs (original similar to HB2558)

Com. Sub. for S. B. 405 - Increasing limit on additional expenses incurred in preparing notice list for redemption

S. B. 461 - Providing for personal income tax withholding on certain lottery winnings

Com. Sub. for S. B. 481 - Relating to Judicial Vacancy Advisory Commission

Eng. Com. Sub. for H. B. 2446 - Blue Alert Plan