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February 5, 2019  
TWENTY-EIGHTH DAY



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Tuesday, February 5, 2019

**TWENTY-EIGHTH DAY**

[DELEGATE HANSHAW, MR. SPEAKER, IN THE CHAIR]

The House of Delegates met at 11:00 a.m., and was called to order by the Honorable Roger Hanshaw, Speaker.

Prayer was offered and the House was led in recitation of the Pledge of Allegiance.

The Clerk proceeded to read the Journal of Monday, February 4, 2019, being the first order of business, when the further reading thereof was dispensed with and the same approved.

**Committee Reports**

Delegate Howell, Chair of the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration:

**H. B. 2528**, Relating to employees of the Commissioner of Agriculture,

And,

**H. B. 2696**, Creating an additional index system for state-owned lands,

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

Delegate Howell, Chair of the Committee on Government Organization, submitted the following report, which was received:

Your Committee on Government Organization has had under consideration:

**H. B. 2392**, Allowing the Alcohol Beverage Control Commissioner to issue special one-day licenses for charitable events,

And reports back a committee substitute therefor, with the same title, as follows:

**Com. Sub. for H. B. 2392** - "A Bill to amend and reenact §11-16-6b of the Code of West Virginia, 1931, as amended; to amend and reenact §11-16-11a of said code, to amend said code by adding thereto a new section, designated §11-16-11b; and to amend said code by adding thereto a new section, designated §60-6-27, all relating to the Alcohol Beverage Control Commissioner; permitting licensed brewpubs, Class A retail dealers, Class B retail dealers, private clubs, Class A retail licensees and Class B retail licensees to serve complimentary samples of nonintoxicating beer or nonintoxicating craft beer manufactured in the State of West Virginia; removing restrictions on Class A retail licensees' ability to serve complimentary nonintoxicating beer samples to customers; permitting the commissioner to issue special one-day licenses for the retail sale of nonintoxicating beer and alcoholic liquors to a duly organized nonprofit corporation, limited liability entity or an

association having received federal tax-exempt status, when raising money for artistic, athletic, charitable, educational or religious purposes,”

And,

**H. B. 2601**, Relating to the review and approval of state property leases,

And reports back a committee substitute therefor, with a new title, as follows:

**Com. Sub. for H. B. 2601** - “A Bill to amend and reenact §5A-10-4 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new section, designated §5A-10-12, all relating to the real estate division; requiring the review and approval of grounds, buildings, office and other space leases; and providing for review and approval of leasing grounds, buildings, office and other space to nongovernmental entities,”

With the recommendation that the committee substitutes each do pass.

Delegate Householder, Chair of the Committee on Finance, submitted the following report, which was received:

Your Committee on Finance has had under consideration:

**H. B. 2545**, Exempting recipients of the distinguished Purple Heart medal from payment of the vehicle registration fee,

And reports back a committee substitute therefor, with the same title, as follows:

**Com. Sub. for H. B. 2545** - “A Bill to amend and reenact §17A-10-8 of the Code of West Virginia, 1931, as amended, relating to exempting recipients of the Purple Heart, Navy Cross, Distinguished Service Cross, Distinguished Flying Cross, Air Force Cross, Bronze Star, Silver Star, or Air Medal medals from payment of the vehicle registration fee for West Virginia residents under defined circumstances,”

And,

**H. B. 2737**, Relating to training of State Tax Division employees,

And reports back a committee substitute therefor, with the same title, as follows:

**Com. Sub. for H. B. 2737** - “A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §11-1-1b, relating to providing training for State Tax Division employees,”

With the recommendation that the committee substitutes each do pass.

Delegate Householder, Chair of the Committee on Finance, submitted the following report, which was received:

Your Committee on Finance has had under consideration:

**H. B. 2546**, Excluding from tax equipment installed in a motor vehicle for use of a person with a medical necessity,

And,

**S. B. 354**, Expiring funds to balance of Auditor's Office - Chief Inspector's Fund,

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

Delegate Butler, Chair of the Committee on Technology and Infrastructure, submitted the following report, which was received:

Your Committee on Technology and Infrastructure has had under consideration:

**H. B. 2390**, Exempting from certain contract and common carrier laws motor vehicles used exclusively in the transportation of railroad personnel,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on the Judiciary.

In accordance with the former direction of the Speaker, the bill (H. B. 2390) was referred to the Committee on the Judiciary.

Delegate Butler, Chair of the Committee on Technology and Infrastructure, submitted the following report, which was received:

Your Committee on Technology and Infrastructure has had under consideration:

**H. B. 2850**, Relating to qualifications for commercial driver's license,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on Government Organization.

In accordance with the former direction of the Speaker, the bill (H. B. 2850) was referred to the Committee on Government Organization.

Delegate Butler, Chair of the Committee on Technology and Infrastructure, submitted the following report, which was received:

Your Committee on Technology and Infrastructure has had under consideration:

**H. B. 2012**, Establishing country roads accountability and transparency,

And reports the same back, with amendment, with the recommendation that it do pass, as amended, but that it first be referred to the Committee on Government Organization.

In accordance with the former direction of the Speaker, the bill (H. B. 2012) was referred to the Committee on Government Organization.

Delegate Maynard, Chair of the Committee on Fire Departments and Emergency Medical Services, submitted the following report, which was received:

Your Committee on Fire Departments and Emergency Medical Services has had under consideration:

**H. B. 2720**, Authorizing certain investigators and first responders to carry firearms,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on the Judiciary.

In accordance with the former direction of the Speaker, the bill (H. B. 2720) was referred to the Committee on the Judiciary.

Delegate Maynard, Chair of the Committee on Fire Departments and Emergency Medical Services, submitted the following report, which was received:

Your Committee on Fire Departments and Emergency Medical Services has had under consideration:

**H. B. 2439**, Relating to fire service equipment and training funds for volunteer and part-volunteer fire companies,

And,

**H. B. 2729**, Recognition of Emergency Medical Services Personnel Licensure Interstate Compact,

And reports the same back with the recommendation that they each do pass, but that they first be referred to the Committee on Government Organization.

In accordance with the former direction of the Speaker, the bills (H. B. 2439 and H. B. 2729) were each referred to the Committee on Government Organization.

Delegate Shott, Chair of the Committee on the Judiciary, submitted the following report, which was received:

Your Committee on the Judiciary has had under consideration:

**H. B. 2740**, Barring a parent from inheriting from a child in certain instances,

And reports back a committee substitute therefor, with a new title, as follows:

**Com. Sub. for H. B. 2740** - "A Bill to amend and reenact §42-1-1 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto two new sections, designated §42-1-11 and §42-1-12, all relating to inheritance; barring a parent from inheriting from or through a child of the parent in certain instances; and permitting a child to inherit from a parent in certain instances,"

With the recommendation that the committee substitute do pass.

Delegate Shott, Chair of the Committee on the Judiciary, submitted the following report, which was received:

Your Committee on the Judiciary has had under consideration:

**H. B. 2365**, Clarifying the definition of an employee for the purposes of unemployment compensation and workers' compensation,

And reports back a committee substitute therefor, with the same title, as follows:

**Com. Sub. for H. B. 2365** - "A Bill to amend and reenact §21A-1A-16 of the Code of West Virginia, 1931, as amended; and to amend and reenact §23-2-1a of said code, relating to the definition of employee for the purposes of the unemployment compensation and workers compensation laws,"

With the recommendation that the committee substitute do pass.

Delegate Shott, Chair of the Committee on the Judiciary, submitted the following report, which was received:

Your Committee on the Judiciary has had under consideration:

**H. B. 2746**, Relating to administration of estates,

**H. B. 2759**, Providing for the ancillary administration of West Virginia real estate owned by nonresidents by affidavit and without administration,

And,

**H. B. 2815**, Raising the value of goods or chattels that are taken in a larceny to constitute grand larceny,

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

Delegate Harshbarger, Chair of the Committee on Agriculture and Natural Resources, submitted the following report, which was received:

Your Committee on Agriculture and Natural Resources has had under consideration:

**H. B. 2716**, Relating to motorboat lighting and equipment requirements,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on Government Organization.

In accordance with the former direction of the Speaker, the bill (H. B. 2716) was referred to the Committee on Government Organization.

Delegate Harshbarger, Chair of the Committee on Agriculture and Natural Resources, submitted the following report, which was received:

Your Committee on Agriculture and Natural Resources has had under consideration:

**H. B. 2709**, Relating to hunting licenses,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on the Judiciary.

In accordance with the former direction of the Speaker, the bill (H. B. 2709) was referred to the Committee on the Judiciary.

Delegate Cooper, Chair of the Committee on Agriculture and Natural Resources, submitted the following report, which was received:

Your Committee on Agriculture and Natural Resources has had under consideration:

**H. B. 2663**, Exempting buildings or structures utilized exclusively for agricultural purposes from the provisions of the State Building Code,

And reports the same back with the recommendation that it do pass, but that it first be referred to the Committee on Government Organization.

In accordance with the former direction of the Speaker, the bill (H. B. 2663) was referred to the Committee on Government Organization.

Delegate Hamrick, Chair of the Committee on Education, submitted the following report, which was received:

Your Committee on Education has had under consideration:

**H. B. 2554**, Relating to transfers and enrollment policies for students in public schools,

And reports back a committee substitute therefor, with the same title, as follows:

**Com. Sub. for H. B. 2554** - "A Bill to repeal §18-5-16a of the Code of West Virginia, 1931, as amended; and to amend and reenact §18-5-16 of said code, relating to transfers and enrollment policies for students in public schools,"

With the recommendation that the committee substitute do pass.

### **Messages from the Senate**

A message from the Senate, by

The Clerk of the Senate, announced that the Senate had passed, with amendment, a bill of the House of Delegates, as follows:

**H. B. 2351**, Relating to regulating prior authorizations.

Delegate Summers moved that the House concur in the following amendment by the Senate, with further amendment:

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

### **ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.**

#### **§5-16-7f. Prior authorization.**

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

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



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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

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

(o) The Department of Health and Human Resources shall have sole authority to enforce the provisions of this section as it relates to medical services paid for by managed care organizations

pursuant to a contract with the department to provide medical services: *Provided*, That the requirements in this subsection shall be expressly memorialized in such contract.

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

## CHAPTER 33. INSURANCE.

### ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

#### **§33-15-4s. Prior authorization.**

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

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

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

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

## **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

### **§33-16-3dd. Prior authorization.**

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

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

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

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

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

### **§33-24-7s. Prior authorization.**

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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



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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

(n) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this

article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

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

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

## **ARTICLE 25. HEALTH CARE CORPORATIONS.**

### **§33-25-8p. Prior authorization.**

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

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

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

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

## **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

### **§33-25A-8s. Prior authorization.**

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

(e) If information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days 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 request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

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

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

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

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

(j) Any 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.

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

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

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

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

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

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

On motion of Delegate Summers, the House concurred in the Senate amendment with further amendment, as follows:

On motion of Delegates Ellington and Hill, the Senate amendment was amended, by striking out the Senate amendment 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 through 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 through 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 through 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 through 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 through 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 through 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."

The bill as amended by the Senate and further amended by the House, was put upon its passage.

On the passage of the bill, the yeas and nays were taken (**Roll No. 72**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (H. B. 2351) passed.

On motion of Delegate Ellington, the title of the bill was amended to read as follows:

**H. B. 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."

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

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 100** - "A Bill to amend and reenact §30-29-4 of the Code of West Virginia, 1931, as amended, relating to increasing a fee added to the usual court costs of all criminal proceedings; and increasing fee added to the amount of any cash or property bond posted for violation of any criminal law, the proceeds of which are dedicated to the funding of training, professional development, and certification programs for law-enforcement officers and to paying the expenses of the Law-Enforcement Professional Standards Subcommittee"; which was referred to the Committee on Finance.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**S. B. 324** - "A Bill to amend and reenact §19-1-3 of the Code of West Virginia, 1931, as amended, relating to employees of the Commissioner of Agriculture."

At the respective requests of Delegate Summers, and by unanimous consent, reference of the bill (S. B. 324) to a committee was dispensed with, and it was taken up for immediate consideration, read a first time and ordered to second reading.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 357** - "A Bill to repeal §15-9A-1, §15-9A-2, §15-9A-3, and §15-9A-4 of the Code of West Virginia, 1931, as amended; to amend and reenact §15A-2-1 and §15A-2-3 of said code; and to amend said code by adding thereto two new sections, designated §15A-2-4 and §15A-2-5, all relating to the Division of Administrative Services; designating division as staffing agency for certain agencies; providing that division perform executive and administrative support services for certain agencies; designating the division as the state administrative agency responsible for criminal justice and juvenile justice systems; providing exception; providing that code references to the Division of Justice and Community Services are to be construed as references to Division of Administrative Services; transferring employees of Division of Justice and Community Services to Division of Administrative Services; enumerating duties of director of division; requiring legislative rulemaking; and providing for posting of human trafficking assistance notices"; which was referred to the Committee on Government Organization.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**S. B. 358** - "A Bill to amend and reenact §15-2D-3 of the Code of West Virginia, 1931, as amended, relating to exempting from the Purchasing Division purchases made by the Director of the Division of Protective Services for equipment to maintain security at state facilities"; which was referred to the Committee on the Judiciary.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate, to take effect from passage, and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 361** - "A Bill to amend and reenact §29-21-6 of the Code of West Virginia, 1931, as amended, relating to Public Defender Services; authorizing the agency's executive director to establish and operate a habeas division; providing that the executive director or his or her designee shall be the director of the division to represent qualified persons in habeas corpus matters; providing

for the representation of eligible clients upon appointment by the circuit courts or the Supreme Court of Appeals; providing for limitations on appointments for conflicts of interest or an excessive caseload; authorizing the executive director to employ attorneys and support staff to perform the duties of the division; and requiring maintenance of client records for record-keeping purposes only”; which was referred to the Committee on the Judiciary.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 369** - “A Bill to amend and reenact §30-5-12b of the Code of West Virginia, 1931, as amended, relating generally to generic drug products; providing definitions; providing that when a pharmacist substitutes a drug the patient shall receive the savings which shall be equal to the difference in acquisition cost of the product prescribed and the acquisition cost of the substituted product; providing an exception for covered individuals; and clarifying that the West Virginia Board of Pharmacy has primary responsibility for enforcement”; which was referred to the Committee on Health and Human Services then the Judiciary.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 373** - “A Bill to amend and reenact §15A-4-11 of the Code of West Virginia, 1931, as amended, relating to the financial responsibility of inmates generally; and authorizing the commissioner of corrections to deduct money from civil judgments and settlements to pay court-ordered obligations prior to depositing such moneys in the inmate’s account”; which was referred to the Committee on the Judiciary then Finance.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**S. B. 377** - “A Bill to amend and reenact §21-5C-1 of the Code of West Virginia, 1931, as amended, relating to minimum wage and maximum hours standards for employees; excluding seasonal amusement park workers from maximum hour requirements; and defining terms”; which was referred to the Committee on the Judiciary.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 389** - “A Bill to amend and reenact §20-2-30a of the Code of West Virginia, 1931, as amended, relating to a lawful method for a developmentally disabled person to purchase a base hunting license when that person attends an on-site hunter training course and successfully completes all nonwritten aspects of the course to receive a certificate but is unable to successfully complete the required course for the certificate of training; providing that said developmentally disabled person possessing the base hunting license may hunt when accompanied and directly supervised by a person 18 years of age or older; and providing for criminal penalties”; which was referred to the Committee on Agriculture and Natural Resources then the Judiciary.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 398** - "A Bill to amend and reenact §5-10-48 of the Code of West Virginia, 1931, as amended; and to amend and reenact §51-9-10 of said code, all relating generally to compensation for judicial officers; providing that senior judges, justices, and magistrates may receive per diem compensation for temporary assignments while receiving retirement benefits, subject to certain limitations; setting forth legislative findings; limiting the per diem rate of compensation that may be paid to senior judges and justices for each day served; providing that the combined total of per diem compensation and retirement benefits paid to a senior judge or justice during a single calendar year may not exceed the annual salary of a sitting circuit judge; providing an exception to the limitation on the combined total of per diem compensation and retirement benefits paid to a senior judge or justice in a calendar year, if the Chief Justice of the Supreme Court of Appeals enters an administrative order certifying that certain circumstances necessitate extended assignment of such judge or justice; requiring that administrative orders regarding extended assignment of a senior judge or justice be submitted to the State Auditor and the State Treasurer; providing that senior judges and justices may be reimbursed for actual and necessary expenses incurred in the performance of their duties; and requiring the State Treasurer to petition the West Virginia Supreme Court of Appeals for a writ of prohibition prohibiting the State Auditor from issuing warrants to authorize payment of compensation to senior judges and justices above statutory limitation on daily rate of per diem compensation"; which was referred to the Committee on the Judiciary then Finance.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate, to take effect from passage, and requested the concurrence of the House of Delegates in the passage, of

**S. B. 399** - "A Bill to amend and reenact §5-10-48 of the Code of West Virginia, 1931, as amended; and to amend and reenact §50-1-6a of said code, all relating generally to compensation for judicial officers; providing that senior judges, justices, and magistrates may receive per diem compensation for temporary assignments while receiving retirement benefits, subject to certain limitations; limiting the per diem rate of compensation that may be paid to senior magistrates for each day served; providing that the combined total of per diem compensation and retirement benefits paid to a senior magistrate during a single calendar year may not exceed the annual salary of a sitting magistrate; providing an exception to the limitation on the combined total of per diem compensation and retirement benefits paid to a senior magistrate in a calendar year, if the Chief Justice of the Supreme Court of Appeals enters an administrative order certifying that certain circumstances necessitate extended assignment of such senior magistrate; requiring that administrative orders regarding extended assignment of a senior magistrate be submitted to the State Auditor and the State Treasurer; and providing that senior magistrates may be reimbursed for actual and necessary expenses incurred in the performance of their duties"; which was referred to the Committee on the Judiciary then Finance.

A message from the Senate, by

The Clerk of the Senate, announced the passage by the Senate and requested the concurrence of the House of Delegates in the passage, of

**Com. Sub. for S. B. 451** - "A Bill to amend and reenact §5-16-2 and §5-16-22 of the Code of the West Virginia, 1931, as amended; to amend and reenact §11-8-6f of said code; to amend said code by adding thereto a new section, designated §11-21-25; to amend said code by adding thereto a new section, designated section §18-1-5; to amend and reenact §18-5-16, §18-5-16a, §18-5-18b, §18-5-32, and §18-5-46 of said code; to amend said code by adding thereto a new section, designated §18-5-45a; to amend said code by adding thereto a new article, designated §18-5G-1, §18-5G-2, §18-5G-3, §18-5G-4, §18-5G-5, §18-5G-6, §18-5G-7, §18-5G-8, §18-5G-9, §18-5G-10, §18-5G-11, §18-5G-12, §18-5G-13, §18-5G-14, and §18-5G-15; to amend and reenact §18-7A-3 of said code; to amend and reenact §18-7B-2 of said code; to amend and reenact §18-8-4 of said code; to amend



and reenact §18-9A-2, §18-9A-8, §18-9A-9, and §18-9A-12 of said code; to amend and reenact §18-20-5 of said code; to amend said code by adding thereto a new article, designated §18-31-1, §18-31-2, §18-31-3, §18-31-4, §18-31-5, §18-31-6, §18-31-7, §18-31-8, and §18-31-9; to amend and reenact §18A-4-2, §18A-4-5, §18A-4-5a, §18A-4-7a, §18A-4-8a, §18A-4-9, and §18A-4-10 of said code; to amend said code by adding thereto a new section, designated §18A-4-2d; to amend and reenact §18A-5-2 of said code; to amend and reenact §18C-4-1, §18C-4-2, §18C-4-3, §18C-4-4, and §18C-4-5 of said code; to amend and reenact §18C-4A-1, §18C-4A-2, and §18C-4-3 of said code; and to amend and reenact §29-12-5a of said code, all relating generally to comprehensive education reform; providing for payment of bonus for accrued sick leave at retirement; modifying regular levy rates; allowing county boards of education to increase their regular levy rates to the statutory maximum; declaring nonseverability of act; providing that central office administrators, supervisors, and directors serve at the will and pleasure of the superintendent; authorizing the establishment of charter schools beginning in 2019-2020; establishing charter school employee permissive participation in the Public Employees Insurance Act; establishing charter school employee eligibility for the State Teachers Retirement System and the Teachers' Defined Contribution Retirement System; providing legislative purpose and intent; defining terms; establishing requirements and powers for public charter schools; providing for the creation of governing boards; setting requirements for enrollment in public charter schools; creating process and requirements for application to establish public charter schools; providing duties and responsibilities for authorizers; providing for virtual charter schools; establishing requirements for charter school contracts and the process for renewal, nonrenewal, and revocation of contracts, including required rules by the State Board of Education; creating the West Virginia Charter Public School Commission; establishing membership of the commission; providing for appointment of members; setting meeting requirements; establishing funding for charter school enrollment; creating appeals process for the denial of a charter application, the nonrenewal of a charter contract, or the revocation of a charter contract; creating prohibitions; allowing charter schools access to public facilities; establishing reporting requirements; providing that appropriation will be disbursed to the public charter schools to serve needs of exceptional children; providing for public charter school coverage by the Board of Risk and Insurance Management; creating personal income tax credits for educational expenses incurred by teachers for the purchase of supplementary educational materials or professional development costs; requiring county boards to establish attendance zones; addressing the transfer and enrollment policies for students in public schools; clarifying the employment term for school employees and the applicability to time lost due to a work stoppage or strike; including teacher recommendations in the considerations for student promotion; expanding social and emotional support services provided to students; clarifying the job duties and responsibilities of school counselors; modifying the contact requirements for a student's guardians upon accrual of unexcused absences; requiring meaningful contact be made with guardians after a student has accrued three and five unexcused absences; specifying that a principal may make meaningful contact with guardians after a student has accrued three unexcused absences; expanding the definition of 'professional student support personnel'; increasing the basic foundation allowance for professional student support personnel; increasing the county allowance for current expenses to 71.25 percent of the county's state average costs per square footage per student for operations and maintenance amount; providing written notice of state Board of Risk and Insurance Management insurance coverage to county board of education insureds; providing that counties with less than 1,400 in net enrollment shall be considered to have 1,400 in net enrollment for the purposes of determining the county's basic foundation program only; enhancing counties' ability to provide additional compensation to teachers; permitting a county board of education to base its employment decisions, transfers, reassignments, reductions in the number of professional personnel, reductions in classroom teaching positions, and reductions in the workforce on an individual's qualifications; setting forth the factors to be considered when determining an individual's qualifications; clarifying payment to teachers and withholdings; enacting an Educational Savings Account Program; providing a short title and definitions; providing basic elements of an Educational Savings Account (ESA); establishing ESA application requirements; defining responsibilities of the Treasurer; establishing a

Parent Review Committee; providing eligibility requirements applicable to education service providers; providing for the responsibilities of resident school districts; addressing legal proceedings; setting local share maximum at 2015-2016 level; increasing salaries for teachers; granting additional experiences for purposes of pay scale to teachers meeting specified requirements; providing additional pay for certain teachers providing math instruction; increasing salaries for service personnel; providing for accrual of personal leave at the end of each pay period; modifying certain student financial aid resources available to students pursuing public school teaching careers; abolishing the Underwood-Smith Teacher Loan Assistance Program; renaming the Underwood-Smith Teacher Scholarship and Loan Assistance Fund as the Underwood-Smith Teaching Scholars Program Fund; modifying program purpose to target certain academic disciplines and emphasize the academic distinction of award recipients; modifying award eligibility, renewal, and service agreement criteria to reflect modified program purpose; requiring certain mentoring services be provided to award recipients; preserving eligibility and service agreement criteria for current award recipients; modifying the amount of an award and limiting tuition and fee charges for program recipients; and requiring annual written notice of BRIM insurance coverages by county boards to employee insureds.”

Delegate Sponaugle moved that the bill be postponed indefinitely.

Delegate Summers moved to table the motion.

On this question, Delegate Caputo demanded the yeas and nays, which demand was sustained.

The yeas and nays having been ordered, they were taken (**Roll No. 73**), and there were—yeas 52, nays 44, absent and not voting 4, with the nays and absent and not voting being as follows:

Nays: Angelucci, Barrett, Bates, Boggs, S. Brown, Byrd, Campbell, Canestraro, Caputo, Dean, Diserio, Doyle, Estep-Burton, Evans, Fleischauer, Fluharty, Hansen, Hartman, Hicks, Hornbuckle, Lavender-Bowe, Longstreth, Lovejoy, McGeehan, Miley, Miller, Paynter, Pethtel, Pushkin, Pyles, Robinson, Rodighiero, Rowe, Skaff, Sponaugle, Staggers, Swartzmiller, C. Thompson, R. Thompson, Tomblin, Toney, Walker, Williams and Zukoff.

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members present and voting having voted in the affirmative, the motion to postpone action on the bill indefinitely was laid upon the table.

The Speaker referred the bill to the Committee on Education then Finance.

A message from the Senate, by

The Clerk of the Senate, announced the adoption by the Senate and requested the concurrence of the House of Delegates in the adoption of the following concurrent resolution, which was read by its title and referred to the Committee on Technology and Infrastructure then Rules:

**S. C. R. 23** - “Requesting the Division of Highways name bridge number 31-7-7.58 (31A311), locally known as Wana Bridge, carrying WV 7 over West Virginia Fork of Dunkard Creek in Monongalia County, the ‘Jeffrey Alan Clovis Memorial Bridge’.”

Whereas, Jeffrey Alan Clovis was born January 29, 1968, and was the first child of Donald Charles Clovis and Linda Kay Tucker of Morgantown, West Virginia, and stepson to Donna Clovis and Darrell Tucker; and

Whereas, Jeffrey Alan Clovis was a 1986 graduate of Clay-Battelle High School, a member of the Loyal Order of Moose in Waynesburg, Pennsylvania, and a member of the Kingdom Evangelical Church of Westover, West Virginia; and

Whereas, Jeffrey Alan Clovis was a 27-year veteran towing operator, receiving a certification of achievement from the Towing Recovery Association of America and was certified as a Nationally Certified Master Tower; and

Whereas, Jeffrey Alan Clovis was known for his good nature and ability to make others feel comfortable in any situation while remaining vigilant in his professional responsibilities; and

Whereas, Jeffrey Alan Clovis of Wadestown, West Virginia, tragically lost his life while responding to a service call along Interstate 79 on August 9, 2016; and

Whereas, Jeffrey Alan Clovis shall be remembered on the Wall of Fallen Heroes at the International Towing and Recovery Hall of Fame in Chattanooga, Tennessee; and

Whereas, Jeffrey Alan Clovis is survived by his wife, Sheila Clovis; daughter, Jennifer Clovis; step-daughter, Skyler Johnson; brother, Brent Clovis; and step-sister, Michelle Yost; and

Whereas, It is fitting that an enduring memorial be established to commemorate Jeffrey Alan Clovis and his contributions to our state; therefore, be it

*Resolved by the Legislature of West Virginia:*

That the Division of Highways is hereby requested to name bridge number 31-7-7.58 (31A311), locally known as Wana Bridge, carrying WV 7 over West Virginia Fork of Dunkard Creek in Monongalia County, the “Jeffrey Alan Clovis Memorial Bridge”; and, be it

*Further Resolved*, That the Division of Highways is hereby requested to have made and be placed signs identifying the bridge as the “Jeffrey Alan Clovis 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.

## **Special Calendar**

### **Third Reading**

**S. B. 268**, Updating meaning of federal taxable income in WV Corporation Net Income Tax Act; on third reading, coming up in regular order, was read a third time.

The question being on the passage of the bill, the yeas and nays were taken (**Roll No. 74**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members present and voting having voted in the affirmative, the Speaker declared the bill (S. B. 268) passed.

Delegate Summers moved that the bill take effect from its passage.

On this question, the yeas and nays were taken (**Roll No. 75**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, two thirds of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (S. B. 268) takes effect from its passage.

*Ordered*, That the Clerk of the House communicate to the Senate the action of the House of Delegates.

**S. B. 269**, Updating terms used in WV Personal Income Tax Act; on third reading, coming up in regular order, was read a third time.

The question being on the passage of the bill, the yeas and nays were taken (**Roll No. 76**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members present and voting having voted in the affirmative, the Speaker declared the bill (S. B. 269) passed.

Delegate Summers moved that the bill take effect from its passage.

On this question, the yeas and nays were taken (**Roll No. 77**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, two thirds of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (S. B. 269) takes effect from its passage.

*Ordered*, That the Clerk of the House communicate to the Senate the action of the House of Delegates.

**Com. Sub. for H. B. 2004**, Providing for a program of instruction in workforce preparedness; on third reading, coming up in regular order, was read a third time.

The question being on the passage of the bill, the yeas and nays were taken (**Roll No. 78**), and there were—yeas 95, nays 1, absent and not voting 4, with the nays and absent and not voting being as follows:

Nays: McGeehan.

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members present and voting having voted in the affirmative, the Speaker declared the bill (Com. Sub. for H. B. 2004) passed.

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

**Com. Sub. for H. B. 2420**, Establishing the Mountaineer Trail Network Recreation Authority; on third reading, coming up in regular order, was read a third time.

The question being on the passage of the bill, the yeas and nays were taken (**Roll No. 79**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members present and voting having voted in the affirmative, the Speaker declared the bill (Com. Sub. for H. B. 2420) passed.

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

**H. B. 2666**, Supplemental appropriation to the Department of Veterans' Assistance; on third reading, coming up in regular order, was read a third time.

On the passage of the bill, the yeas and nays were taken (**Roll No. 80**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (H. B. 2666) passed.

Delegate Summers moved that the bill take effect from its passage.

On this question, the yeas and nays were taken (**Roll No. 81**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, two thirds of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (H. B. 2666) takes effect from its passage.

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

**H. B. 2668**, Supplemental appropriation to the Department of Administration, Public Defender Services; on third reading, coming up in regular order, was read a third time.

On the passage of the bill, the yeas and nays were taken (**Roll No. 82**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, a majority of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (H. B. 2668) passed.

Delegate Summers moved that the bill take effect from its passage.

On this question, the yeas and nays were taken (**Roll No. 83**), and there were—yeas 96, nays none, absent and not voting 4, with the absent and not voting being as follows:

Absent and Not Voting: N. Brown, Kump, Storch and Worrell.

So, two thirds of the members elected to the House of Delegates having voted in the affirmative, the Speaker declared the bill (H. B. 2668) takes effect from its passage.

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

### **Second Reading**

**Com. Sub. for H. B. 2363**, Relating to the Upper Kanawha Valley Resiliency and Revitalization Program; on second reading, coming up in regular order, was read a second time.

An amendment, offered by Delegates Rowe and Robinson, was reported by the Clerk, on page three, section fifteen, line sixty-three, following the dash, by inserting the following:

“(1) The council shall prioritize programs by requiring that, if proper applications are made, resources and funding are directed to the Upper Kanawha Valley communities to support economic development efforts of the Upper Kanawha Valley. The council agencies shall be flexible with regard to the programmatic uses of resources and funding provided that such uses do not violate federal or state laws governing the use of said resources and funding.

(2) The council shall direct the resources of contributing partners, as applicable, to support the Upper Kanawha Valley” and a period.

And renumbering the subsequent subdivisions accordingly.

And,

On page four, section fifteen, lines seventy-six and seventy-seven, by striking out the words “discretionary, noncompetitive”.

Whereupon,

Delegate Robinson asked and obtained unanimous consent that the amendment be withdrawn.

The bill was then ordered to engrossment and third reading.

**Com. Sub. for H. B. 2490**, Preventing proposing or enforcing rules that prevent recreational water facilities from making necessary upgrades; on second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

**H. B. 2691**, Providing that a license to carry a concealed deadly weapon expires on the holder’s birthday; on second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

**Com. Sub. for H. B. 2779**, Providing that proceeds from certain oil and gas wells to persons whose name or address are unknown are to be kept in a special fund; on second reading, coming up in regular order, was read a second time and ordered to engrossment and third reading.

### **First Reading**

The following bills on first reading, coming up in regular order, were each read a first time and ordered to second reading:

**Com. Sub. for S. B. 240**, Repealing certain legislative rules no longer authorized or are obsolete,

**Com. Sub. for H. B. 2204**, Prohibiting state licensing boards from hiring lobbyists,

**Com. Sub. for H. B. 2479**, Corporate Governance Annual Disclosure Act,

**Com. Sub. for H. B. 2481**, Permitting retail sale of alcoholic beverages on Sundays after 1 p.m.,

**H. B. 2608**, Repealing the requirement of printing the date a consumer deposit account was opened on paper checks,

And,

**Com. Sub. for H. B. 2686**, Relating to permitting the Supreme Court of Appeals of West Virginia to create a family drug court pilot program.

### **Leaves of Absence**

At the request of Delegate Summers, and by unanimous consent, leaves of absence for the day were granted Delegates N. Brown, Kump, Storch and Worrell.

### **Miscellaneous Business**

During First Reading, Delegate Pyles was recognized and asked and obtained unanimous consent that he be added as a cosponsor of H. B. 2481.

Pursuant to House Rule 94b, Members filed forms with the Clerk's Office to be added as a cosponsor of the following:

- Delegate Bibby for H. B. 2033
- Delegates Estep-Burton, Mandt and McGeehan for H. B. 2046
- Delegate Pyles for H. B. 2130, H. B. 2729, H. B. 2836 and H. B. 2846
- Delegate Wilson for H. B. 2708
- Delegates Harshbarger and Mandt for H. B. 2740
- Delegate Phillips for H. B. 2805

Pursuant to House Rule 132, unanimous consent was requested and obtained to print the remarks of the following Members in the Appendix to the Journal:

- All Members during Remarks by Members

- Delegate Sponaugle regarding the motion to postpone indefinitely Com. Sub. for S. B. 451

At 12:29 p.m., the House of Delegates adjourned until 11:00 a.m., Wednesday, February 6, 2019.

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**HOUSE OF DELEGATES**  
**STEPHEN J. HARRISON, Clerk**  
**Building 1, Room M-212**  
**1900 Kanawha Blvd., East**  
**Charleston, WV 25305-0470**





## **SPECIAL CALENDAR**

**Wednesday, February 6, 2019**

**29<sup>th</sup> Day**

**11:00 A. M.**

### **THIRD READING**

- Com. Sub. for H. B. 2363 - Relating to the Upper Kanawha Valley Resiliency and Revitalization Program (HAMRICK) (REGULAR)
- Com. Sub. for H. B. 2490 - Preventing proposing or enforcing rules that prevent recreational water facilities from making necessary upgrades (ELLINGTON) (REGULAR)
- H. B. 2691 - Providing that a license to carry a concealed deadly weapon expires on the holder's birthday (SHOTT) (REGULAR)
- Com. Sub. for H. B. 2779 - Providing that proceeds from certain oil and gas wells to persons whose name or address are unknown are to be kept in a special fund (ANDERSON) (REGULAR)

### **SECOND READING**

- Com. Sub. for S. B. 240 - Repealing certain legislative rules no longer authorized or are obsolete (JUDICIARY COMMITTEE AMENDMENT PENDING) (SHOTT) (REGULAR)
- S. B. 324 - Relating to Commissioner of Agriculture employees (HOWELL) (EFFECTIVE FROM PASSAGE)
- Com. Sub. for H. B. 2204 - Prohibiting state licensing boards from hiring lobbyists (SHOTT) (REGULAR)
- Com. Sub. for H. B. 2479 - Corporate Governance Annual Disclosure Act (SHOTT) (REGULAR)
- Com. Sub. for H. B. 2481 - Permitting retail sale of alcoholic beverages on Sundays after 1 p.m. (SHOTT) (REGULAR)
- H. B. 2608 - Repealing the requirement of printing the date a consumer deposit account was opened on paper checks (NELSON) (REGULAR)
- Com. Sub. for H. B. 2686 - Relating to permitting the Supreme Court of Appeals of West Virginia to create a family drug court pilot program (SHOTT) (REGULAR)

## FIRST READING

- S. B. 354 - Expiring funds to balance of Auditor's Office - Chief Inspector's Fund (HOUSEHOLDER) (EFFECTIVE FROM PASSAGE)
- Com. Sub. for H. B. 2365 - Clarifying the definition of an employee for the purposes of unemployment compensation and workers' compensation (SHOTT) (REGULAR)
- Com. Sub. for H. B. 2392 - Allowing the Alcohol Beverage Control Commissioner to issue special one-day licenses for charitable events (HOWELL) (REGULAR)
- H. B. 2528 - Relating to employees of the Commissioner of Agriculture (HOWELL) (REGULAR)
- Com. Sub. for H. B. 2545 - Exempting recipients of the distinguished Purple Heart medal from payment of the vehicle registration fee (HOUSEHOLDER) (REGULAR)
- H. B. 2546 - Excluding from tax equipment installed in a motor vehicle for use of a person with a medical necessity (HOUSEHOLDER) (REGULAR)
- Com. Sub. for H. B. 2554 - Relating to transfers and enrollment policies for students in public schools (HAMRICK) (JULY 1, 2019)
- Com. Sub. for H. B. 2601 - Relating to the review and approval of state property leases (HOWELL) (REGULAR)
- H. B. 2696 - Creating an additional index system for state-owned lands (HOWELL) (REGULAR)
- Com. Sub. for H. B. 2737 - Relating to training of State Tax Division employees (HOUSEHOLDER) (REGULAR)
- Com. Sub. for H. B. 2740 - Barring a parent from inheriting from a child in certain instances (SHOTT) (REGULAR)
- H. B. 2746 - Relating to administration of estates (SHOTT) (REGULAR)
- H. B. 2759 - Providing for the ancillary administration of West Virginia real estate owned by nonresidents by affidavit and without administration (SHOTT) (REGULAR)
- H. B. 2815 - Raising the value of goods or chattels that are taken in a larceny to constitute grand larceny (SHOTT) (REGULAR)

**HOUSE CALENDAR**

**Wednesday, February 6, 2019**

**29<sup>th</sup> Day**

**11:00 A. M.**

**SECOND READING**

Com. Sub. for H. B. 2008 - Relating to nonpartisan election of justices of the Supreme Court of Appeals (SHOTT) (REGULAR)

**WEST VIRGINIA  
HOUSE OF DELEGATES**

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**WEDNESDAY, FEBRUARY 6, 2019**

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**HOUSE CONVENES AT 11:00 A.M.**

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**COMMITTEE ON FINANCE  
9:00 A.M. – ROOM 460M**

**COMMITTEE ON THE JUDICIARY  
9:00 A.M. – ROOM 418M**

**COMMITTEE ON EDUCATION  
9:00 A.M. – ROOM 432M**

**COMMITTEE ON GOVERNMENT ORGANIZATION  
9:00 A.M. – ROOM 215E**

**COMMITTEE ON RULES  
10:45 A.M. – BEHIND THE CHAMBER**

**VETERANS AFFAIRS & HOMELAND SECURITY  
1:00 P.M. – ROOM 432M**





HOUSE OF DELEGATES  
STEPHEN J. HARRISON, Clerk  
Building 1, Room M-212  
1900 Kanawha Blvd., East  
Charleston, WV 25305-0470