HARRIS FRAZIER

Government Relations

PHARM

SB168/HB85 **CRIMINAL LAW: Free All Cannabis for Tennesseans Act.**

Sponsors: Sen. Campbell, Heidi , Rep. Freeman, Bob

Summary: Enacts the "Free All Cannabis for Tennesseans Act" or "FACT Act," which establishes a regulatory structure for the cultivation, processing, and retail sale of marijuana and marijuana products in this state to be administered by the department of agriculture. Authorizes an adult to use, possess, and transport not more than 60 grams of marijuana, except that not more than 15 grams of that amount may be in the form of marijuana concentrate. Defines "marijuana concentrate" to mean the cannabinoid-rich oil or extract from marijuana extracted from plant material or the resin created from the plant by physical or chemical means and includes water-based marijuana concentrate, food-based marijuana concentrate, solvent-based marijuana concentrate, and heat- or pressure-derived marijuana concentrate. Authorizes an adult to transfer without remuneration to another adult not more than 60 grams of marijuana, except that not more than 15 grams of that amount may be in the form of marijuana concentrate. Specifies that the transfer must not be advertised or promoted to the public. Authorizes an adult to cultivate for personal use no more than 12 marijuana plants in an area on the premises of the adult's private residence. Allows a person to prohibit or restrict the possession, consumption, cultivation, distribution, manufacture, sale, or display of marijuana or marijuana products on property the person owns, occupies, or manages. Authorizes a county, by resolution of the county legislative body, or an incorporated municipality, by ordinance of its governing body, to levy a local sales tax in a rate not to exceed five percent on the sale of marijuana and marijuana products within such county or municipality. Also imposes a 15 percent tax on each sale of marijuana or a marijuana product by a marijuana dispensary. Requires the department of revenue to allocate the revenue derived from the marijuana tax and specifies allocation (37 pp.).

Fiscal Note: (Dated April 10, 2023) Increase State Revenue Net Impact - $65,256,000/FY24-25/General Fund $134,742,400/FY25-26/General Fund $134,782,400/FY26-27/General Fund $134,955,200/FY27-28 and Subsequent Years/General Fund HB 85 - SB 168 3 $63,454,600/FY24-25/Department of Agriculture $126,909,200/FY25-26 and Subsequent Years/ Department of Agriculture $25,381,800/FY24-25/Department of Safety $50,763,700/FY25-26 and Subsequent Years/ Department of Safety $25,381,800/FY24-25/ State Employee Legacy Pension Stabilization Reserve Trust $50,763,700/FY25-26 and Subsequent Years/ State Employee Legacy Pension Stabilization Reserve Trust $6,345,500/FY24-25/Department of Education $12,690,900/FY25-26 and Subsequent Years/ Department of Education $6,345,500/FY24-25/Department of Revenue $12,690,900/FY25-26 and Subsequent Years/ Department of Revenue $600/Each FY24-25 through FY26-27/Department of State $200/FY27-28 and Subsequent Years/Department of State Increase State Expenditures $232,300/FY24-25/Department of Revenue $223,900/FY25-26 and Subsequent Years/ Department of Revenue $1,713,900/FY24-25/Department of Agriculture $785,900/FY25-26 and Subsequent Years/ Department of Agriculture Decrease State Expenditures - $71,100/FY23-24/Incarceration $143,500/FY24-25/Incarceration $144,900/FY25-26 and Subsequent Years/Incarceration Increase Local Revenue Net Impact $65,486,600/FY24-25 $131,083,400/Each FY25-26 through FY26-27 $131,166,000/FY27-28 and Subsequent Years Decrease Local Expenditures - $10,525,800/FY23-24 $21,051,600/FY24-25 and Subsequent Years HB 85 - SB 168 4 Other Fiscal Impact Decreases in incarceration expenditures will continue through FY32-33. Exact amounts of annual decreases over the next 10 years are included below. Additionally, this legislation could result in reduced expenditures for incarceration at the state and local level, and increased expenditures at the state and local for additional public benefits; however, due to multiple unknown variables, any such impacts cannot be reasonably determined at this time.

Senate Status: 01/21/23 - Referred to Senate Judiciary Committee.

House Status: 03/26/24 - Taken off notice in House Criminal Justice Subcommittee.

SB502/HB916 **TENNCARE: Report on use and cost of opioids and other controlled substances in prescription drug program.**

Sponsors: Sen. Watson, Bo , Rep. Rudder, Iris

Summary: Extends, from January 15 to February 1 of each calendar year, the due date of the annual report required to be submitted by the bureau of TennCare to certain legislative committees on the use and cost of opioids and other controlled substances in the prescription drug program for the TennCare program. Broadly captioned.

Amendment Summary: House amendment 1 (012739) rewrites this bill to add the following provisions relative to clinician-administered drugs, which are outpatient prescription drugs, other than vaccines, (i) that either cannot reasonably be self-administered by the patient or an individual assisting the patient or for which the prescriber has ordered administration by a healthcare provider and (ii) that is administered by a healthcare provider in a clinical setting: (1) This amendment generally prohibits a health insurance entity from conditioning, denying, restricting, refusing to authorize or approve, failing to cover, or reducing payment to a participating healthcare provider for a clinician-administered drug solely because (i) the clinician-administered drug is either purchased or administered by a participating healthcare provider or (ii) the participating healthcare provider obtained the clinician-administered drug from a pharmacy that is not a contracted provider in the health insurance entity's network; (2) This amendment requires a health insurance entity to comply with the above provision only if (i) the terms of the health insurance contract that do not conflict with the above provisions, including the covered person's health insurance coverage benefits and medical necessity criteria, can also be met; and (ii) the clinician-administered drug meets the requirements set forth in federal law; (3) This amendment requires a health insurance entity to pay a participating healthcare provider at the rate for the clinician-administered drug set forth in the health insurance entity's agreement with the participating healthcare provider, or, if no rate is included in the agreement, at a rate not less than the health insurance entity's median rate of reimbursement currently payable to all providers in the health insurance entity's provider network for the clinician-administered drug; (4) This amendment prohibits a health insurance entity from requiring a covered person to pay an additional fee or other increased cost-sharing amount for a clinician-administered drug administered by a participating healthcare provider solely because the drug is (i) purchased and administered by the participating healthcare provider or (ii) obtained by the participating healthcare provider from a pharmacy that is not a contracted provider in the health insurance entity's network; (5) This amendment prohibits a health insurance entity from authorizing or permitting another person or entity acting on its behalf to administer claims or benefits under a health insurance contract in violation of this amendment; (6) This amendment does not prohibit a health insurance entity from establishing differing copayments or other cost-sharing amounts within the health insurance contract for a covered person who receives a clinician-administered drug administered by a healthcare provider who is not contracted with the health insurance entity; (7) This amendment does not prohibit a health insurance entity from refusing to authorize or approve, or denying coverage of, a clinician-administered drug based upon a failure to satisfy the required terms of coverage in the health insurance contract, including medical necessity criteria; (8) This amendment requires a health insurance entity that has established a specialty pharmacy network to establish a process under which requests for authorization by a healthcare provider to administer clinician-administered drugs are handled in accordance with this amendment. If the healthcare provider treating the covered person submits an urgent care request, then the health insurance entity must provide review and determination; (9) Except as provided in this amendment, a health insurance entity's specialty pharmacy network in existence as of January 1, 2025, is not subject to the requirements of this amendment, as long as the following is true: (A) The health insurance entity does not control, directly or through an affiliate, a specialty pharmacy that is participating in the health insurance entity's specialty pharmacy network; (B) The health insurance entity contracts with specialty pharmacies in this state at rates no less than the median of reimbursement rates applicable to other specialty pharmacies in the network and with the same terms and conditions applicable to other specialty pharmacies in the network. A specialty pharmacy seeking inclusion in the network must meet the reasonable credentialing standards established by the health insurance entity; and (C) When a healthcare provider participating in the health insurance entity's provider network obtains a clinician-administered drug for a covered person from a source other than the health insurance entity's specialty pharmacy network, the health insurance entity reimburses the participating healthcare provider in an amount no less than the amount that would apply if the clinician-administered drug had been obtained from a pharmacy in the specialty pharmacy network; (10) This amendment is not applicable to TennCare, the CoverKids program, or health benefit plans for public officers and employees; and (11) This amendment applies to contracts for health insurance entered into, amended, or renewed on or after January 1, 2025. Senate amendment 2 (017441) excludes the medical assistance program established under title 71, chapter 5, the CoverKids program, health benefit plans for public officers and employees established under title 8, chapter 27, and grandfathered health plan coverage under the federal Patient Protection and Affordable Care Act.

Fiscal Note: (Dated January 26, 2023) NOT SIGNIFICANT

Senate Status: 04/15/24 - Failed in Senate after adopting amendment 2 (017441), which excludes the medical assistance program established under title 71, chapter 5, the CoverKids program, health benefit plans for public officers and employees established under title 8, chapter 27, and grandfathered health plan coverage under the federal Patient Protection and Affordable Care Act.
House Status: 03/07/24 - House passed with amendment 1 (012739).

SB620/HB1414 **FAMILY LAW: Families' Rights and Responsibilities Act.**

Sponsors: Sen. Pody, Mark , Rep. Raper, Kevin
Summary: Enacts the "Families' Rights and Responsibilities Act", which declares that the ability of a parent to direct the upbringing, education, health care, and mental health of that parent's child is a fundamental right. Details how to bring a suit for potential violations of this act. Broadly captioned.
Fiscal Note: (Dated March 24, 2023) NOT SIGNIFICANT
Senate Status: 02/27/24 - Taken off notice in Senate Judiciary Committee.
House Status: 02/07/23 - Referred to House Children & Family Affairs Subcommittee.

SB667/HB920 **INSURANCE HEALTH: Extension of audit notice for pharmacist or pharmacy.**

Sponsors: Sen. Reeves, Shane , Rep. Rudder, Iris
Summary: Extends from two weeks to 30 days the period of time a pharmacist or pharmacy must be provided written notice prior to a covered entity, pharmacy benefits manager, the state or a political subdivision of the state, or a party representing such entity begins an initial on-site audit for an audit cycle. Broadly captioned.
Fiscal Note: (Dated January 28, 2023) NOT SIGNIFICANT
Senate Status: 03/12/24 - Taken off notice in Senate Commerce & Labor Committee.
House Status: 03/19/24 - Taken off notice in House Insurance Subcommittee.

SB869/HB282 **HEALTH CARE: Practice of pharmacy.**

Sponsors: Sen. Reeves, Shane , Rep. Baum, Charlie
Summary: Authorizes as part of the practice of pharmacy the prescribing of dietary fluoride supplements, certain immunization agents, opioid antagonists, and certain other drugs and products. Makes various other changes to pharmacy practice including professional judgement and health and safety. Broadly captioned.
Amendment Summary: Senate amendment 1 (015768) rewrites the bill to, instead, add to the present law definition of "practice of pharmacy," as described below. This amendment establishes that the "practice of pharmacy" also includes the issuing of a prescription or medical order of the following drugs, drug categories, or devices, excluding controlled substances, that are issued in accordance with the product's federal FDA-approved labeling or guidelines of the centers for disease control and prevention that are limited to the following: (1) Antivirals for influenza and COVID-19 that are waived under the federal clinical laboratory improvement amendments of 1988, upon completion of a test that is used to guide diagnosis or clinical decision-making; (2) Agents for active immunization when prescribed for susceptible persons for the protection from communicable disease for individuals who are 18 and older, and agents for active immunization for influenza and COVID-19 for individuals who are 3 to 17 years old; however, the pharmacists must comply with recordkeeping and reporting requirements, including (i) informing the patient's primary care provider, if the patient identifies a primary care provider; (ii) submitting the required immunization information to this state's vaccine registry; (iii) complying with requirements related to reporting adverse events; and (iv) reviewing the patient's vaccine history, if any, through this state's vaccine registry or other vaccination records prior to administering a vaccine; (3) Post-exposure prophylaxis for nonoccupational exposure to HIV infection, and the ordering of lab tests in conjunction with initiation of therapy; (4) Epinephrine auto-injectors for patients with a documented history of allergies or anaphylactic reactions; (5) Progesterone-only hormonal contraceptives; (6) Naloxone; (7) Dietary fluoride supplements for those over seven, when prescribed according to the American Dental Association's recommendations for persons whose drinking water is proven to have a fluoride content below the U.S. department of health and human services' recommended concentration; and (8) Tuberculin purified protein derivative products in compliance with current statutory reporting requirements. This amendment establishes that the standard of care for a pharmacist providing the services listed in (1)-(8) above is the same standard of care as a physician ordering or providing the same service. House amendment 1 (017275) establishes that the practice of pharmacy includes the issuing of a prescription or medical order for certain drugs, drug categories, or devices, excluding controlled substances, that are issued in accordance with the product's federal Food and Drug Administration (FDA) approved labeling or guidelines of the Centers for Disease Control and Prevention (CDC). Establishes that issuing such a prescription or medical order is not considered the practice of medicine as defined for physicians. Establishes that the standard of care for a pharmacist providing such services is the same standard of care as a physician ordering or providing the same service.
Fiscal Note: (Dated January 24, 2023) NOT SIGNIFICANT
Senate Status: 04/18/24 - Signed by Senate speaker.
House Status: 04/18/24 - Signed by House speaker.
Executive Status: 04/19/24 - Sent to governor.

SB1170/HB1457 **HEALTH CARE: Due date for renewal of fees by professional or registered nurse.**

Sponsors: Sen. Swann, Art , Rep. Cochran, Mark
Summary: Increases the length of notice the executive director of the board must give a person holding a current licensure registration to practice as a professional or registered nurse that the renewal fee is due, from 60 days to 65 days prior to the due date of the renewal fee. Broadly captioned.
Amendment Summary: Senate Commerce & Labor Committee amendment 1 (006457) expands the scope of practice of physician assistants and makes changes to collaboration requirements for physician assistants. Authorizes a physician assistant with greater than 6,000 hours of postgraduate clinical experience to apply to the Board of Physician Assistants (Board) for an endorsement on the physician assistant's license and to practice independently without a collaborating physician. Establishes that a physician assistant with fewer than 6,000 hours of postgraduate clinical experience must collaborate with a physician and may only hold a minority ownership interest in a healthcare setting. Authorizes a physician assistant to render emergency medical services in cases where immediate diagnosis and treatment are necessary to avoid disability or death. Establishes that a physician assistant who has received an endorsement certifying greater than 6,000 hours of postgraduate clinical experience may prescribe, dispense, order, administer, and procure appropriate medical devices, legend drugs, and controlled substances that are within the physician assistant's scope of practice, experience, and training, if the physician assistant has registered and complied with all applicable requirements of state law and rules and the federal drug enforcement administration. Requires the Board to monitor the prescriptive practices of physician assistants through site visits. Takes effect January 1, 2024.
Fiscal Note: (Dated February 3, 2023) NOT SIGNIFICANT
Senate Status: 03/28/23 - Senate Health & Welfare Committee deferred to first calendar of 2024.
House Status: 01/30/24 - Taken off notice in House Health Subcommittee.

SB1394/HB1227 **MENTAL HEALTH: Public posting of the written minutes of each Tennessee opioid abatement council meetings.**

Sponsors: Sen. Reeves, Shane , Rep. Littleton, Mary
Summary: Requires the department of mental health and substance abuse services to make available on its public website an electronic copy of the written minutes of each meeting of the Tennessee opioid abatement council. Broadly captioned.
Fiscal Note: (Dated February 5, 2023) NOT SIGNIFICANT
Senate Status: 02/06/23 - Referred to Senate Judiciary Committee.
House Status: 02/02/23 - House sponsor changed from Tom Leatherwood to Mary Littleton.

SB1575 **PROFESSIONS & LICENSURE: Occupational licensing - proof of citizenship.**

Sponsors: Sen. Roberts, Kerry ,
Summary: As an alternative for an applicant for a health-related professional license or certificate having to show US citizenship or authorization to work in the United States as verified by the SAVE program, allows the applicant to show proof of application for a valid visa that would authorize the applicant to lawfully work in the United States. Requires the board of medical examiners to grant a full and unrestricted license to practice medicine to certain temporary licensees who are in good standing two years after the temporary licensee begins practicing medicine at a healthcare provider in this state as a temporary licensee, rather than two years after the date of initial licensure. Broadly captioned.
Senate Status: 01/29/24 - Withdrawn in Senate.

SB1677/HB1824 **MENTAL HEALTH: Companies involved in pending or future claims regarding opioids.**

Sponsors: Sen. Haile, Ferrell , Rep. Farmer, Andrew
Summary: Adds The Kroger Co. to the list of companies that are released by the attorney general and reporter for pending or future claims regarding opioids.
Fiscal Note: (Dated January 28, 2024) NOT SIGNIFICANT Other Fiscal Impact - In the event that the state enters into and reaches a settlement with any of the entities outlined in this legislation, there will be an increase in foregone state revenue and a corresponding increase in local revenue. The precise amount of any such settlement cannot be reasonably determined.
Senate Status: 03/06/24 - Signed by Senate speaker.
House Status: 03/06/24 - Signed by House speaker.
Executive Status: 04/03/24 - Enacted as Public Chapter 0568 effective March 15, 2024.

SB1765/HB1956 **GOVERNMENT REGULATION: Importation of prescription drugs from Canada.**

Sponsors: Sen. Lamar, London , Rep. Miller, Larry
Summary: Requires the department of finance and administration, in collaboration with the department of health and the bureau of TennCare, to apply for federal approval to import prescription drugs from Canada. Requires the department to notify the governor, speaker of the house of representatives and speaker of the senate upon receipt of federal approval. Requires the department of finance and administration to develop a plan to implement a program within six months of federal approval. Broadly captioned.
Fiscal Note: (Dated February 15, 2024) Other Fiscal Impact - The timing and extent of a waiver approval from the federal Department of Health and Human Services is unknown. The implementation of such waiver is also dependent on the cooperation of the Canadian government. Therefore, the fiscal impact of any future program for the importation of prescription drugs cannot be reasonably quantified.
Senate Status: 02/20/24 - Failed in Senate Commerce & Labor Committee.
House Status: 01/25/24 - Referred to House Insurance Subcommittee.

SB1829 **AGRICULTURE: Medical Autonomy Related to Cannabis Act.**

Sponsors: Sen. Lamar, London ,
Summary: Enacts the "Medical Autonomy Related to Cannabis Act" which allows the growing and selling of medical marijuana for sale or transfer to a medical marijuana dispensary. Allows an individual to engage in the personal use of medical marijuana if certain conditions are met. Allows for the prohibition of marijuana possession by private property owners. Detail violations of using medicinal marijuana. Details the application and license fees for medical marijuana micro-grow licensees. Allows for a local sales tax of 3% on all medicinal marijuana sales. Removes marijuana from drug sniffing dogs categories and drug paraphernalia definitions. (45pps). Broadly captioned.
Senate Status: 01/29/24 - Referred to Senate Judiciary Committee.

SB1881/HB2857 **INSURANCE HEALTH: Provider-based telemedicine requirements.**

Sponsors: Sen. Massey, Becky , Rep. Hill, Timothy
Summary: Removes from the definition of "provider-based telemedicine" the requirement that the healthcare service provider or the provider's practice group or healthcare system have an established provider-patient relationship that is documented by an in-person encounter within 16 months prior to the interactive visit.
Amendment Summary: Senate amendment 1 (013830) rewrites the bill to, instead, make the changes described below to the present law relevant to provider-based telemedicine. Present law provides for the use of HIPAA-compliant real-time, interactive audio, video telecommunications, or electronic technology, or asynchronous computer-based communications or transfer of medical data ("store-and-forward telemedicine services"), used over the course of an interactive visit by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when the following conditions are met: (1) The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient; (2) The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in telecommunications as described under present law; (3) The healthcare services provider makes use of HIPAA-compliant real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of practice of the healthcare services provider as long as the healthcare services provider, the healthcare services provider's practice group, or the healthcare system has established a provider-patient relationship by submitting to a health insurance entity evidence of an in-person encounter between the healthcare service provider, the healthcare services provider's practice group, or the healthcare system and the patient within 16 months prior to the interactive visit; (4) The requirement of an in-person encounter between the healthcare services provider, the healthcare services provider's practice group, or the healthcare system and the patient within 16 months prior to the interactive visit is tolled for the duration of a state of emergency declared by the governor if the healthcare services provider or the patient, or both, are located in the geographical area covered by the applicable state of emergency; and (5) The requirement of an in-person encounter between the healthcare services provider, the healthcare services provider's practice group, or the healthcare system and the patient within 16 months prior to the interactive visit does not apply to a patient who is receiving an initial behavioral health evaluation or assessment. This amendment revises the present law in (3) above requiring that the evidence be submitted prior to the interactive visit and removes "within 16 months". This amendment deletes the present law in (4) above and, instead, requires that the healthcare services provider, the healthcare services provider's practice group, or the healthcare system is able to render the healthcare services through an in-person encounter. Finally, this amendment revises the present law in (5) above by removing "within 16 months."
Fiscal Note: (Dated February 7, 2024) NOT SIGNIFICANT
Senate Status: 03/21/24 - Senate passed with amendment 1 (013830).
House Status: 04/24/24 - House passed.
Executive Status: 04/24/24 - Sent to the speakers for signatures.

SB1904/HB2039 **TAXES BUSINESS: Tax credits equal to unreimbursed TennCare costs for certain healthcare providers.**

Sponsors: Sen. Hensley, Joey , Rep. Butler, Ed
Summary: Authorizes business, excise, and franchise tax credits equal to unreimbursed TennCare costs for eligible healthcare providers that provide healthcare services to TennCare recipients. Allows a refund to be issued in lieu of a tax credit on the condition that the refund be used to make a charitable contribution.
Amendment Summary: House Insurance Subcommittee amendment 1 (015604) requires TennCare to certify an eligible healthcare provider's unreimbursed costs in a calendar year as charitable contributions made exclusively for public purposes and provide the total amount of such charitable contributions to the healthcare provider. Takes effect Jul, 1, 2024.
Fiscal Note: (Dated March 3, 2024) Decrease State Revenue $3,256,300/FY24-25 $244,654,600/FY25-26 and Subsequent Years
Senate Status: 04/22/24 - Set for Senate Finance, Ways & Means Committee 04/23/24.
House Status: 03/26/24 - Taken off notice in House Insurance Committee.

SB1915/HB1859 **PROFESSIONS & LICENSURE: Occupational licensing for individuals with a criminal record.**

Sponsors: Sen. Niceley, Frank , Rep. Davis, Elaine
Summary: Prohibits certain licensing authorities from automatically barring an individual from licensure because of the individual's criminal record. Requires the licensing authority to provide individualized consideration of an individual's criminal record and circumstances. Specifies which convictions a licensing authority may consider in deciding for licensure. Makes other changes related to licensure determinations and criminal records including not using a vague term in its consideration and its notice or decision, including good moral character, moral turpitude, or character and fitness. (11pp). Broadly captioned.
Amendment Summary: House amendment 1 (016022) prohibits a licensing authority under the Division of Health-Related Boards or a licensing authority under the Department of Commerce and Insurance from using vague terms including terms such as good moral character or character and fitness, in its considerations and its notices or decisions without also explaining how a prior conviction directly relates to the applicable occupation, profession, business, or trade, if such prior conviction serves as a basis for the licensing authority's consideration and notice or decision.
Fiscal Note: (Dated March 9, 2024) Other Fiscal Impacts Due to multiple unknown variable, the net impact on state license fee revenue cannot be quantified with reasonable certainty.
Senate Status: 04/10/24 - Signed by Senate speaker.
House Status: 04/10/24 - Signed by House speaker.
Executive Status: 04/23/24 - Signed by governor.

SB2008/HB2170 **INSURANCE HEALTH: Pharmacy benefits - availability of financial or other product assistance for a prescription drug.**

Sponsors: Sen. Reeves, Shane , Rep. Williams, Ryan

Summary: Prohibits an insurer, pharmacy benefits manager, or third-party administrator from changing or conditioning the terms of health plan coverage based on availability of financial or other product assistance for a prescription drug. Establishes certain procedures for calculating an enrollee's contribution to an applicable cost sharing requirement. Broadly captioned.

Amendment Summary: Senate Commerce & Labor Committee amendment 1, House Insurance Committee amendment 1 (015555) establishes, for contracts for health insurance coverage entered into, amended, extended, or renewed after July 1, 2021, that if the calculation of an enrollee's contribution to an applicable cost sharing requirement by a health insurance entity would result in health savings account (HSA) ineligibility under federal law, then the requirement for such calculation applies for HSA-qualified high deductible health plans with respect to the deductible of such a plan only after the enrollee has satisfied the minimum deductible, except for items or services that are preventive care. Specifies this does not apply to a prescription drug for which there is a generic alternative or an interchangeable biological product, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the health insurance entity's exceptions and appeals process, or the determination of a prescriber. Prohibits a health insurance entity, pharmacy benefits manager, or third-party administrator from setting, altering, implementing, or conditioning the terms of health insurance coverage based on information about the availability or amount of financial or product assistance available for a prescription drug. Establishes that prior to entering into an agreement with a patient for the purpose of obtaining financial or product assistance from a patient assistance program administered by a pharmaceutical manufacturer, charitable organization, or governmental entity to assist in the payment or procurement of prescription drugs for a patient, a health insurance entity, pharmacy benefits manager, or third-party administrator must disclose certain information in writing to the patient. Effective upon becoming a law, and applies only to health plans entered into, amended, extended, or renewed on or after January 1, 2025.

Fiscal Note: (Dated February 14, 2024) NOT SIGNIFICANT

Senate Status: 03/27/24 - Taken off notice in Senate Commerce & Labor Committee.

House Status: 03/28/24 - Taken off notice in House Calendar & Rules Committee.

SB2011/HB2903 **TENNCARE: Use of drugs for the treatment of pain.**

Sponsors: Sen. Reeves, Shane , Rep. Kumar, Sabi

Summary: Requires the division of TennCare to ensure that a non-opioid drug approved by the United States food and drug administration for the treatment or management of pain is not disadvantaged or discouraged with respect to coverage relative to an opioid or narcotic drug for the treatment or management of pain on the preferred drug list. Makes other changes regarding the use of opioids and non-opioid drugs including notification to the patient and potential addiction if the person has a high risk of, or has a history of, controlled substance abuse or misuse. Broadly captioned.

Amendment Summary: House amendment 1 (015009) rewrites the bill to, instead, do the following: (1) Authorize the division of TennCare ("division"), in its sole discretion, to adopt or amend a state preferred drug list (PDL). The adoption or amendment of a PDL, and the recommendations of the TennCare pharmacy advisory committee to the division, are not agency actions and do not require rulemaking; (2) In establishing and maintaining the PDL, require the division to ensure that a non-opioid drug approved by the FDA for the treatment or management of pain is not disadvantaged or discouraged with respect to coverage relative to any opioid or narcotic drug for the treatment or management of pain on the PDL. However, this provision does not prohibit an opioid medication from being preferred over other opioid medications, or a non-opioid medication from being preferred over other non-opioid medications; (3) Establish that the bill applies to a non-opioid drug immediately upon its approval by the FDA for the treatment or management of pain, regardless of whether the drug has been reviewed by the division for inclusion on the PDL. The bill also applies to drugs being provided under a contract between the division and any managed care organization; (4) Define, for purposes of the bill, a "non-opioid treatment" as a drug or biological product that is indicated to produce analgesia without acting on the body's opioid receptors; (5) Require the division to ensure that reimbursement is provided to a healthcare provider who provides a non-opioid treatment to a recipient under the medical assistance program; (6) Require the division to ensure that, to the extent permitted by law, a hospital that provides either inpatient or outpatient services to a recipient is reimbursed under the medical assistance program for any medically necessary non-opioid treatment provided as a part of those services; and (7) When a licensed physician prescribes a non-opioid medication for the treatment of acute or chronic pain, prohibit a managed care organization or other health insurance issue from denying coverage of the non-opioid prescription drug in favor of an opioid prescription drug. House amendment 2 (015364) revises the bill to prohibit a managed care organization or other health insurance issuer from denying coverage of a non-opioid prescription drug in favor of an opioid prescription drug when a healthcare prescriber, instead of a licensed physician, prescribes a non-opioid medication for the treatment of acute or chronic pain.

Fiscal Note: (Dated February 16, 2024) Increase State Expenditures $2,412,200/FY24-25 $1,886,200/FY25-26 and Subsequent Years Increase Federal Expenditures $4,465,700/FY24-25 $3,491,800/FY25-26 and Subsequent Years

Senate Status: 04/08/24 - Signed by Senate speaker.

House Status: 04/04/24 - Signed by House speaker.

Executive Status: 04/22/24 - Signed by governor.

SB2016/HB2086 **HEALTH CARE: Requirements for 340B entities receiving federal grant funds.**

Sponsors: Sen. Reeves, Shane , Rep. Helton-Haynes, Esther

Summary: Requires a 340B entity that receives federal grant funds through § 317 or § 318 of the Public Health Service Act to enter into an agreement with the department on such terms and conditions as the commissioner may require in order to be eligible to receive in-kind funds from the state or a political subdivision of the state on or after July 1, 2024. Broadly captioned.

Amendment Summary: Senate amendment 1 (015039) rewrites the bill to, instead, prohibit the department of health from permitting a corporation to receive in-kind contributions paid for by federal grant funds through the federal Public Health Service Act.

Fiscal Note: (Dated March 1, 2024) NOT SIGNIFICANT

Senate Status: 04/04/24 - Signed by Senate speaker.

House Status: 04/05/24 - Signed by House speaker.

Executive Status: 04/25/24 - Enacted as Public Chapter 0684 effective April 1, 2024.

SB2019/HB2060 **HEALTH CARE: Prescribed buprenorphine products.**

Sponsors: Sen. Reeves, Shane , Rep. Hicks, Tim

Summary: Increases from 50 to 100 the number of patients to whom a licensed nurse practitioner or physician assistant who is authorized to prescribe Schedule II or III drugs may prescribe buprenorphine products. Increases from four to 10 the maximum number of licensed nurse practitioners or physician assistants who prescribe buprenorphine products that a physician may supervise or collaborate with at one time. Makes other changes relative to the use of buprenorphine products. Broadly captioned.

Amendment Summary: Senate amendment 1 (015859) clarifies that a healthcare provider who is not licensed under state law relative to medicine and surgery, or to osteopathic physicians, and who is otherwise permitted to prescribe Schedule II or III drugs under state law, is prohibited from prescribing any buprenorphine product for the treatment of opioid use disorder unless the provider is supervised by or collaborates with a physician who is limited to the supervision of, or collaboration for, a maximum of five, rather than four, licensed nurse practitioners or physician assistants.

Fiscal Note: (Dated March 8, 2024) NOT SIGNIFICANT

Senate Status: 03/25/24 - Senate passed with amendment 1 (015859).

House Status: 04/11/24 - House passed.

Executive Status: 04/11/24 - Sent to the speakers for signatures.

SB2031/HB2123 **GOVERNMENT REGULATION: Report of requirements for prescribing and dispensing medication in contiguous states.**

Sponsors: Sen. Reeves, Shane , Rep. Terry, Bryan

Summary: Requires the commissioner study laws in contiguous states concerning requirements for prescribing and dispensing medication and submit a report of findings to the chair of the health and welfare committee of the senate, the chair of the health committee of the house of representatives, and the legislative librarian on or before December 31, 2024. Broadly captioned.

Fiscal Note: (Dated January 28, 2024) NOT SIGNIFICANT

Senate Status: 01/31/24 - Referred to Senate Commerce & Labor Committee.

House Status: 01/29/24 - Caption bill held on House clerk's desk.

SB2048/HB1825 **CRIMINAL LAW: Increase in the limit on the amount of products containing ephedrine or pseudoephedrine base that a pharmacy may sell.**

Sponsors: Sen. Stevens, John , Rep. Farmer, Andrew

Summary: Increases the limit on the amount of products containing ephedrine or pseudoephedrine base, or their salts, isomers, or salts of isomers that a pharmacy may sell or a person may purchase in a 30-day period from 5.76 grams to 7.2 grams. Removes the limit on the amount of such products that may be purchased or sold within a one-year period.

Amendment Summary: Senate amendment 1 (015567) makes the following changes: (1) Prohibits a pharmacy from selling products containing ephedrine or pseudoephedrine base, or their salts, isomers, or salts of isomers to the same person in an amount more than 43.2 grams in any one-year period; and (2) Prohibits a person from purchasing products containing ephedrine or pseudoephedrine base, or their salts, isomers, or salts of isomers in an amount more than 43.2 grams in any one-year period.

Fiscal Note: (Dated January 17, 2024) NOT SIGNIFICANT

Senate Status: 04/10/24 - Senate passed with amendment 1 (015567).

House Status: 04/16/24 - House passed.

Executive Status: 04/16/24 - Sent to the speakers for signatures.

SB2080/HB1683 **GOVERNMENT REGULATION: Obsolete references to federal law pertaining to prescription of controlled substances.**

Sponsors: Sen. Johnson, Jack , Rep. Lamberth, William

Summary: Removes obsolete references to federal law that pertain to the prescription of certain controlled substances. Part of Administration Package.

Fiscal Note: (Dated January 17, 2024) NOT SIGNIFICANT

Senate Status: 03/07/24 - Signed by Senate speaker.

House Status: 03/06/24 - Signed by House speaker.

Executive Status: 04/03/24 - Enacted as Public Chapter 0575 effective March 15, 2024.

SB2104/HB2502 **AGRICULTURE: Tennessee Medical Autonomy Related to Cannabis Act.**

Sponsors: Sen. Lamar, London , Rep. Harris, Torrey

Summary: Enacts the "Tennessee Medical Autonomy Related to Cannabis Act," which authorizes a licensed medical marijuana grower, including a director, manager, or employee of the grower, acting within the scope of the grower's license to operate a facility to grow marijuana for sale or transfer to a medical marijuana establishment, including the sale or transfer of seeds, flower, mother plants, mature plants, immature plants, or clones and possess medical marijuana or medical marijuana-related products. Details who can engage in the personal use of medical marijuana and how they are protected from prosecution. Details violations of using medicinal marijuana and punishments if convicted. Describes that the department of agriculture has rule-making authority and oversight. Details the application and license fees. Allows for licenses to be revoked and reinstated. Authorizes a local sales tax at a rate not to exceed 3% on the sale of medical marijuana and medical marijuana products. Describes how the collected tax is allocated. (45pp.). Broadly captioned.

Fiscal Note: (Dated March 5, 2024) Increase State Revenue Net Impact - $48,101,400/FY24-25/General Fund $48,035,600/FY25-26/General Fund $48,503,300/FY26-27/General Fund Exceeds $49,011,500/FY27-28 and Subsequent Years/General Fund $300/FY24-25/Secretary of State $100/FY25-26 and Subsequent Years/Secretary of State $3,800/FY24-25/Tennessee Bureau of Investigation $800/FY25-26/Tennessee Bureau of Investigation $900/FY26-27/Tennessee Bureau of Investigation $1,100/FY27-28 and Subsequent Years/Tennessee Bureau of Investigation $2,140,300/FY24-25/Department of Agriculture $4,305,400/FY25-26/Department of Agriculture $4,330,300/FY26-27/Department of Agriculture SB 2104 - HB 2502 3 $4,355,500/FY27-28 and Subsequent Years/Department of Agriculture $2,996,400/FY24-25/Department of Safety $6,027,500/FY25-26/Department of Safety $6,062,500/FY26-27/Department of Safety $6,097,600/FY27-28 and Subsequent Years/Department of Safety $1,284,200/FY24-25/Department of Education $2,583,200/FY25-26/Department of Education $2,598,200/FY26-27/Department of Education $2,613,300/FY27-28 and Subsequent Years/Department of Education $428,100/FY24-25/Department of Revenue $861,100/FY25-26/Department of Revenue $866,100/FY26-27/Department of Revenue $871,100/FY27-28 and Subsequent Years/Department of Revenue $1,712,200/FY24-25/State Employee Legacy Pension Stabilization Reserve Trust $3,444,300/FY25-26/State Employee Legacy Pension Stabilization Reserve Trust $3,464,300/FY26-27/State Employee Legacy Pension Stabilization Reserve Trust $3,484,400/FY27-28/State Employee Legacy Pension Stabilization Reserve Trust Increase State Expenditures - $2,155,000/FY24-25/General Fund $1,215,600/FY25-26 and Subsequent Years/General Fund Decrease State Expenditures - $71,600/FY24-25 Incarceration $144,500/FY25-26 Incarceration $145,900/FY26-27 Incarceration Increase Local Revenue Net Impact - $16,372,700/FY24-25 $32,925,900/FY25-26 $33,115,200/FY26-27 $33,305,100/FY27-28 and Subsequent Years Other Fiscal Impact Some medical marijuana tax revenue is earmarked to be used for grants to tier 3 and 4 counties and support of law enforcement injuries and deaths. SB 2104 - HB 2502 4This will result in an increase in state expenditures to the DOA and DOS and an equal increase in local revenue. The amount and timing of such increases cannot be reasonably determined. This legislation could result in reduced expenditures for incarceration at the state and local level in terms of bail, parole, probation, or suspended sentences and increase expenditures at the state and local for additional public benefits; however, due to multiple unknown variables, any such impact cannot be reasonably determined at this time.

Senate Status: 03/26/24 - Senate Judiciary Committee deferred to 04/02/24.

House Status: 03/26/24 - Failed in House Health Subcommittee.

SB2125/HB2557 **TENNCARE: Eligibility for minor child.**

Sponsors: Sen. Kyle, Sara , Rep. Shaw, Johnny

Summary: Requires that on and after July 1, 2025, a minor child who is enrolled in TennCare or the CoverKids program remains eligible for TennCare or the CoverKids program until the minor child reaches six years of age. Prohibits the Bureau of Tenncare from subjecting the minor child to a redetermination of eligibility or disenrollment except under certain circumstances, including the minor child no longer residing in the state. Requires the director to submit any necessary federal waiver request by December 31, 2024. Broadly captioned.

Fiscal Note: (Dated March 4, 2024) Increase State Expenditures $1,790,300/FY25-26 and Subsequent Years Increase Federal Expenditures $3,314,400/FY25-26 and Subsequent Years

Senate Status: 03/13/24 - Failed in Senate Health & Welfare Committee for lack of a second.

House Status: 03/19/24 - Taken off notice in House Insurance Committee.

SB2136/HB2318 **HEALTH CARE: Scope of practice of physician assistants and advanced practice nurses.**

Sponsors: Sen. Reeves, Shane , Rep. Williams, Ryan

Summary: Makes revisions to the authorized scope of practice of physician assistants and advanced practice nurses who meet certain qualifications (35 pp.).

Amendment Summary: House amendment 2 (017953) rewrites the bill as follows: (1) Authorizes a physician assistant to do the following: (A) Perform medical diagnosis and treatment as a physician assistant pursuant either to a protocol or collaborative agreement, as applicable, for which the physician assistant has been prepared by education, training, and experience, and that the physician assistant is competent to perform only if licensed by the board of physician assistants ('board") and only within the usual scope of practice of the collaborating physician; (B) Perform minor surgical procedures, including (i) simple laceration or surgery repair; (ii) excision of skin lesions, moles, warts, cysts, or lipomas; (iii) incision and draining of superficial abscesses; (iv) skin biopsies; (v) arthrocentesis; (vi) thoracentesis; (vii) paracentesis; (viii) endometrial biopsies; (ix) IUD insertion; and (x) colposcopy; (C) Assist a physician who performs procedures considered Level II office-based surgery or Level III office-based surgery, as those are defined in state law, or a more complex procedure, if (i) the physician assistant is credentialed or receives privileges from the medical staff of the facility to assist a physician with enumerated procedures; (ii) the physician performing the procedure is credentialed or privileged to perform the procedure by the medical staff of the facility; and (iii) the physician is present or immediately available for consultation with the physician assistant during and after the procedure; (D) Issue drugs authorized by law pursuant to protocols or collaborative agreement, and as applicable, (i) prescribe, dispense, order, administer, and procure appropriate medical devices, legend drugs, and controlled substances that are within the physician assistant's scope of practice if the physician assistant has registered and complied with all applicable requirements of state law and rule and the federal drug enforcement administration; and (ii) only prescribe or issue a Schedule II or Schedule III opioid for a maximum of a nonrefillable, thirty-day course of treatment. This (1)(D) does not apply to a prescription issued in a hospital, a licensed nursing home, or a licensed inpatient facility; (E) Unless a physician assistant's protocols or collaborative agreement indicate otherwise, plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including (i) durable medical equipment; (ii) nutrition; (iii) blood and blood products; and (iv) diagnostic support services that include, but are not limited to, home health care, hospice, and physical and occupational therapy; and (F) Complete, sign, and file medical certifications of death, if authorized to do so in the physician assistant's protocol or collaborative agreement; (2) Requires a physician assistant who has not received endorsement from the board to practice under protocols jointly developed by the collaborating physician and the physician assistant; (3) Requires the physician assistant to maintain a copy of the protocols either on paper or electronically at each of the physician assistant's practice locations and make the protocols available upon request by the board, the licensing board of the collaborating physician, or an authorized agent thereof; (4) Requires the protocols to set forth the range of services that may be provided by the physician assistant and must also contain a discussion of the problems and conditions likely to be encountered by the physician assistant and the appropriate treatment for such problems and conditions; (5) Establishes that physician assistant practice under protocols requires active and continuous overview of the physician assistant's activities to ensure that the

conditions; (5) Establishes that physician assistant practice under protocols requires active and continuous overview of the physician assistant's activities to ensure that the physician's directions and advice are implemented, but does not require the continuous and constant physical presence of the collaborating physician; (6) Authorizes a physician assistant to perform only those tasks that are within the physician assistant's range of skills and competence, that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of the patients; (7) Requires protocols to also include, at a minimum, the following: (A) The physician assistant's name, license number, and primary practice location; (B) The collaborating physician's name, license number, medical specialty, and primary practice location; (C) A general description of the oversight of the physician assistant by the collaborating physician; (D) A general description of the physician assistant's process for collaboration with physicians and other members of the healthcare team; (E) A process by which 100 percent of patient charts are reviewed by the collaborating physician within 10 days when a prescription for a controlled drug is issued by the physician assistant; (F) A process by which at least 20 percent of the physician assistant's patient charts are reviewed by the collaborating physician every 30 days; (G) If the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which the patient medical charts prepared by the physician assistant are reviewed by the collaborating physician for a minimum of six months or until the physician assistant becomes eligible for endorsement, whichever period is longer; (H) If the physician assistant practices in a remote location site from the collaborating physician's practice site, that the collaborating physician conduct a remote site visit at least every 30 days; (I) That the physician assistant collaborates with, consults with, or refers to, the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care when a patient presents with a condition that is outside of the competence, scope of practice, or experience of the physician assistant or collaborating physician; and (J) Designation of one or more alternative physicians for consultation in situations in which the collaborating physician is not available for consultation; (8) Requires a physician assistant who has received an endorsement from the board to have a collaborative agreement with a physician; (9) Requires the physician assistant to maintain a copy of the collaborative agreement either on paper or electronically at each of the physician assistant's practice locations and make the collaborative agreement available upon request by the board of physician assistants, the licensing board of the collaborating physician, or an authorized agent of such boards; (10) To be eligible to receive endorsement from the board, requires a physician assistant to, at a minimum, have 6,000 hours of documented postgraduate clinical experience, have a physician willing to enter into a collaborative agreement with the physician assistant, and meet such other requirements as set forth in rules promulgated by the board. A physician assistant with 6,000 hours or more of documented postgraduate clinical experience must not practice pursuant to the requirements in state physician assistant law or rules promulgated thereto for endorsed physician assistants without first receiving endorsement by the board. State physician assistant law does not require a physician assistant to become endorsed by the board. Unless a physician assistant has received an endorsement from the board, the requirements under this heading apply; (11) Requires collaborative agreements governing physician assistants who have 6,000 or more hours of documented postgraduate clinical experience and are endorsed by the board to include, at a minimum, the following: (i) the physician assistant's name, license number, and primary practice location; (ii) the collaborating physician's name, license number, medical specialty, and primary practice location; (iii) that the physician assistant performs only those services that are within the physician assistant's competence, knowledge, and skills that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of patients; (iv) a process by which 100 percent of patient charts are reviewed by the collaborating physician within 30 days when a prescription for any drug containing buprenorphine for use in recovery or medication treatment or a Schedule II controlled drug is issued by the physician assistant; (v) that if the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which a sample of patient medical charts prepared by the physician assistant are reviewed by the collaborating physician, or a physician designated by the collaborating physician, for a minimum of six months; (vi) that the physician assistant collaborates with, consults with, or refers to the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care; (vii) methods of communication between the physician assistant and collaborating physician; and (viii) requirements of patient chart review and remote site visits, if any, established at the practice level and commensurate with the level of training, experience, and competence of the physician assistant within the expected scope of practice of the physician assistant; (12) Establishes that, regarding a physician assistant practicing in collaboration with a licensed podiatrist, in addition to meeting the requirements of other relevant state law, the following apply: (i) prohibits providing services that are outside the scope of practice of a podiatrist; (ii) requires complying with the requirements of, and rules adopted pursuant to, the bill and other relevant state law governing the collaboration with a physician assistant; and (iii) authorizes only prescribing drugs that are rational to the practice of podiatry; (13) Authorizes a physician assistant to render emergency medical services in cases where immediate diagnosis and treatment are necessary to avoid patient death or disability; (14) Establishes that the standard of care for a physician assistant is the same standard of care as applicable to a physician who performs the same service; (15) Requires that the initial rules governing the collaborative agreements of physician assistants with licensed physicians be established and promulgated in accordance with the Uniform Administrative Procedures Act, by a task force composed of (i) one member from the board of medical examiners; (ii) one member from the board of osteopathic examination; (iii) one member from the board of podiatric medical examiners; and (iv) three members from the board of physician assistants; (16) Requires the task force to create uniform rules governing the collaboration of physician assistants with licensed physicians, which are binding on each board listed in (15); (17) Requires the rules created by the taskforce to create standard procedures to determine the responsibility for the review of patient medical charts; (18) Requires each board listed in (15) to select and appoint by a majority vote of its members a board member to serve on the task force before September 1, 2024; (19) Requires the task force to select and appoint a member to serve as chair of the task force; (20) Establishes that a majority of the task force constitutes a quorum, and a majority vote of the task force members present is required for any action; (21) Requires the task force to hear public comment at any required hearing on behalf of all boards listed in (15) when a hearing is required. The task force is authorized to vote to promulgate the rules governing the collaboration of physician assistants with licensed physicians for each board listed in (15); (22) Requires the task force to terminate upon the effective date of a permanent rule establishing collaboration pursuant to the bill. All future rules regarding collaboration pursuant to the bill after the termination of the task force must be adopted jointly by each relevant board in (15); (23) Establishes that the bill does not prohibit the licensing boards listed in (15) from promulgating additional rules regarding the licensees of such boards; (24) Requires a licensed physician collaborating with a physician assistant to comply with the following practices: (A) Ensure that protocols or a collaborative agreement, as applicable, is in place for each physician assistant with whom the physician collaborates and that such protocols or collaborative agreement meets the requirements of the bill and the duly promulgated rules. More than one physician may collaborate with the same physician assistant if alternative collaborating physicians are available to collaborate with the physician assistant in the absence or unavailability of the primary collaborating physician. Each physician assistant must notify the board of physician assistants of the name, address, and license number of the physician assistant's primary collaborating physician and notify the board of physician assistants of a change in the primary collaborating physician within 15 days of the change. The number of physician assistants for whom a physician may serve as the collaborating physician must be determined by the physician at the practice level, consistent with good medical practice. The collaborating physician must designate one or more alternate physicians who have agreed to accept the responsibility of collaborating with the physician assistant on a prearranged basis in the collaborating physician's absence; (B) Complete the patient chart reviews of each physician assistant with whom the collaborating physician collaborates as set forth in the bill, in rules promulgated pursuant to the bill, and in protocols or a collaborative agreement, as applicable; (C) Conduct reviews of charts submitted to the collaborating physician by the physician assistant deemed by the physician assistant medically indicated for consultation. The collaborating physician is responsible for reviewing 100 percent of patient charts within 30 days when the physician assistant issues a prescription for a controlled drug pursuant to protocols. The collaborating physician is responsible for reviewing 100 percent of patient charts within 30 days when the physician assistant issues a prescription for any drug containing buprenorphine for use in recovery or medication-assisted treatment or a Schedule II controlled drug pursuant to a collaborative agreement; (D) Conduct the requisite remote site visits with each physician assistant with whom the physician collaborates, as set forth in the bill or by rule, and in protocols or a collaborative agreement, as applicable; (E) Each physician assistant must notify the board of the name and address of the physician assistant's primary practice location and notify the board within 15 days of a practice location change; (F) The board of physician assistants is authorized to monitor the prescriptive practices of the physician assistant through site visits by members of the board or their authorized agents; (G) Complaints against physician assistants must be reported to the office of investigations of the division of health related boards; (H) Every prescription order issued by a physician assistant pursuant to the bill must be entered in the medical records of the patient, and every handwritten prescription must be written on a preprinted prescription pad bearing the name, address, and telephone number of the physician assistant, and the physician assistant must sign each prescription order so written; (I) A handwritten prescription order for a drug prepared by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, handwritten in letters or in numerals, instructions for the proper use of the drug and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant must sign the handwritten prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility; (J) A typed or computer-generated prescription order for a drug issued by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription order. The typed or computer-generated prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, recorded in letters or in numerals, instructions for the proper use of the drug, and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant must sign the typed or computer-generated prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility; (K) The bill does not prevent a physician assistant from issuing a verbal prescription order; (L) Handwritten, typed, or computer-generated prescription orders must be issued on either tamper-resistant prescription paper or printed utilizing a technology that results in a tamper-resistant prescription that meets the current centers for Medicare and Medicaid services guidance to state Medicaid directors regarding § 7002(b) of the federal United States Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, and meets or exceeds specific TennCare requirements for tamper-resistant prescriptions; (M) Establishes that (L) does not apply to prescriptions written for inpatients of a hospital, outpatients of a hospital where the doctor or other person authorized to write prescriptions writes the order into the hospital medical record and then the order is given directly to the hospital pharmacy and the patient never has the opportunity to handle the written order, a nursing home or an assisted-care living facility, inpatients or residents of a mental health hospital or residential facility, or individuals incarcerated in a local, state, or federal correctional facility; (N) A physician assistant authorized to

prescribe drugs under the bill who provides services in a free or reduced fee clinic under the Volunteer Health Care Services Act may arrange for required personal review of the physician assistant's charts by a collaborating physician in the office or practice site of the physician or remotely via HIPAA-compliant electronic means rather than at the site of the clinic; (O) A physician assistant authorized to prescribe drugs under the bill who provides services in a community mental health center, or federally qualified health center, or solely via telehealth, may arrange for the required personal review of the physician assistant's charts by a collaborating physician, with the same authority to render prescriptive services that the physician assistant is authorized to render, in the remote office or practice site of the physician, or any required visit by a collaborating physician to any remote site, or both, via HIPAA-compliant electronic means rather than at the site of the clinic; (P) A physician assistant licensed to prescribe drugs who provides services at a remote healthcare setting may arrange for any required personal review of the physician assistant's charts by a collaborating physician either via HIPAA-compliant electronic means or in person; (Q) A physician assistant licensed to prescribe drugs may arrange for up to 10 of the required annual remote site visits by a collaborating physician by HIPAA-compliant electronic means rather than at the site of the clinic. All other of the required site visits by a collaborating physician to a remote site must take place in person at the site of the clinic. As used in this subdivision, "annual" means a rolling twelve-month period; (R) A patient receiving services from a physician assistant must be fully informed that the individual is a physician assistant and a sign must be conspicuously placed within the office indicating that certain services may be rendered by a physician assistant; (S) A physician who does not normally provide patient care must not enter into protocols with, collaborate with, or utilize the services of a physician assistant; (T) A physician assistant must only perform invasive procedures involving a portion of the spine, spinal cord, sympathetic nerves of the spine, or block of major peripheral nerves of the spine in any setting not licensed as a health facility or resource, under the direct supervision of a licensed physician licensed who is actively practicing spinal injections and has current privileges to do so at a licensed facility. The direct supervision provided by a physician in this (T) must only be offered by a physician who meets the qualifications established in state law relative to interventional pain management; (U) For purposes of subdivision (T), "direct supervision" means being physically present in the same building as the physician assistant at the time the invasive procedure is performed; and (V) This (V) does not apply to a physician assistant performing major joint injections, except sacroiliac injections, or to performing soft tissue injections or epidurals for surgical anesthesia or labor analgesia in unlicensed settings; (25) Requires that the board exercise its powers under state law on the grounds of holding oneself out as board-certified in a medical specialty, or utilizing a medical specialty designation with (i) a title or title reference; (ii) an advertisement; (iii) the name of any healthcare setting that is majority-owned by physician assistants; (iv) credentialing with any licensed healthcare facility or health insurance entity; or (v) an application for healthcare liability insurance coverage; (26) Establishes that (25) is not grounds for discipline of a licensee who worked in a healthcare setting that used a medical specialty designation prior to January 1, 2024, as long as: (A) The licensee's collaborating physician (i) is board-certified or board eligible in the designated specialty; (ii) owns part of the practice that provided the services in such healthcare setting; and (iii) sees patients in such healthcare setting on a regular basis; (B) Ownership of the practice has not changed on or after January 1, 2024; (C) Prior to March 1, 2025, a licensee who practices in a healthcare setting described in (26) must submit proof satisfactory to the board that the licensee's healthcare setting meets the requirements of (26); and (D) If a licensee who, prior to March 1, 2025, meets the requirements of (26), ceases to meet such requirements on or after March 1, 2025, then the licensee must notify the board within 30 days; (27) Authorizes the funeral director who first assumes custody of a dead body, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement to sign and file the death certificate. The funeral director, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement must obtain the personal data from the next of kin or the best qualified person or source available, and obtain the medical certification from the person responsible for medical certification; (28) Requires medical certification to be completed, signed, and returned to the funeral director by the physician or physician assistant in charge of the patient's care for the illness or condition that resulted in death within 48 hours after death, except when inquiry is required by the county medical examiner or to obtain a veteran's medical records. In the absence of the physician or physician assistant, the certificate may be completed and signed by another physician designated by the physician, by the chief medical officer of the institution in which the death occurred, or by a physician assistant authorized by protocol or collaborative agreement. In cases of deaths that occur outside of a medical institution and are either unattended by a physician or physician assistant, or not under hospice care, the county medical examiner must investigate and certify the death certificate when one of the following conditions exists: (A) There is no physician or physician assistant who had attended the deceased during the four months preceding death, except that a physician or physician assistant authorized by protocol or collaborative agreement who had attended the patient more than four months preceding death may elect to certify the death certificate if the physician or physician assistant authorized by protocol or collaborative agreement can make a good faith determination as to cause of death and if the county medical examiner has not assumed jurisdiction; or (B) The physician who had attended the deceased during the four months preceding death or physician assistant authorized by protocol or collaborative agreement communicates, orally or in writing, to the county medical examiner that, in the physician's or physician assistant's best medical judgment, the patient's death did not result from the illness or condition for which the physician or physician assistant was attending the patient; (29) If the cause of death cannot be determined within 48 hours after death, requires that the medical certification be completed as provided by rule. The attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement must give the funeral director notice of the reason for the delay, and final disposition of the body must not be made until authorized by the attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement; (30) For purposes of this heading, "referral" means a written or telecommunicated authorization for genetic counseling services from a physician licensed to practice medicine in all its branches or a physician assistant who has protocols or a collaborative agreement with a supervising physician that authorizes referrals to a genetic counselor; (31) Authorizes a physician order for scope of treatment (POST) to be issued by a physician assistant for a patient with whom the physician assistant has a bona fide physician assistant-patient relationship only if, among other conditions, such authority to issue is contained in the physician assistant's protocols or collaborative agreement; (32) Authorizes a POST to be issued by a physician assistant for a patient with whom the physician assistant has a bona fide physician assistant-patient relationship only if, among other conditions, the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available and such authority to issue is contained in the physician assistant's protocols or collaborative agreement, and the physician assistant determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards; (33) Requires that a licensed physician assistant have the same authority that a physician has under this heading to issue certified statements of disability or deafness to accompany the application of disabled or deaf persons to obtain the appropriate registration, license plates, placards and decals from the department, only if the authority is expressly included in the written protocol or collaborative agreement developed jointly by the supervising physician and the physician assistant, setting forth the range of services that may be performed by the physician assistant; (34) Requires the board of medical examiners to establish and maintain an online registry of licensed physicians who are willing to enter into a collaborative agreement with a physician assistant; (35) Requires the online registry to include, at a minimum (i) the physician's name and physical practice address; (ii) designation as a medical doctor or doctor of osteopathy; (iii) the physician's medical specialty and board certifications, if any; (iv) the region or regions of the state in which the physician is willing to enter into a collaborative agreement with a physician assistant; and (v) an address, telephone number, or email address at which the physician can be contacted by a physician assistant who may desire to enter into a collaborative relationship with the physician; (36) Requires a physician included on the registry to update the physician's information described in (35); (37) Establishes that inclusion by a physician on the registry does not obligate a physician to enter into a collaborative agreement with a physician assistant; (38) Prohibits the bill from being construed to prohibit service rendered by a registered nurse, a licensed practical nurse, or a pharmacist pursuant to a collaborative pharmacy practice agreement, if such service is rendered under the supervision, control and responsibility of a licensed physician or to prohibit the provision of anesthesiology services in licensed health care facilities by a dentist licensed in this state who completed a residency program in anesthesiology at an accredited medical school in years 1963 through 1977; and (39) Prohibits the bill from being construed to prohibit service rendered by a physician assistant practicing in collaboration with a physician, osteopathic physician, or podiatrist, whether through protocols or a collaborative agreement. Senate amendment 1 (017651) rewrites the bill as follows: (1) Authorizes a physician assistant to do the following: (A) Perform medical diagnosis and treatment as a physician assistant pursuant either to a protocol or collaborative agreement, as applicable, for which the physician assistant has been prepared by education, training, and experience, and that the physician assistant is competent to perform only if licensed by the board of physician assistants ("board") and only within the usual scope of practice of the collaborating physician; (B) Perform minor surgical procedures, including (i) simple laceration or surgery repair; (ii) excision of skin lesions, moles, warts, cysts, or lipomas; (iii) incision and draining of superficial abscesses; (iv) skin biopsies; (v) arthrocentesis; (vi) thoracentesis; (vii) paracentesis; (viii) endometrial biopsies; (ix) IUD insertion; and (x) colposcopy; (C) Assist a physician who performs procedures considered Level II office-based surgery or Level III office-based surgery, as those are defined in state law, or a more complex procedure, if (i) the physician assistant is credentialed or receives privileges from the medical staff of the facility to assist a physician with enumerated procedures; (ii) the physician performing the procedure is credentialed or privileged to perform the procedure by the medical staff of the facility; and (iii) the physician is present or immediately available for consultation with the physician assistant during and after the procedure; (D) Issue drugs authorized by law pursuant to protocols or collaborative agreement, and as applicable, (i) prescribe, dispense, order, administer, and procure appropriate medical devices, legend drugs, and controlled substances that are within the physician assistant's scope of practice if the physician assistant has registered and complied with all applicable requirements of state law and rule and the federal drug enforcement administration; and (ii) only prescribe or issue a Schedule II or Schedule III opioid for a maximum of a nonrefillable, thirty-day course of treatment. This (1)(D) does not apply to a prescription issued in a hospital, a licensed nursing home, or a licensed inpatient facility; (E) Unless a physician assistant's protocols or collaborative agreement indicate otherwise, plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including (i) durable medical equipment; (ii) nutrition; (iii) blood and blood products; and (iv) diagnostic support services that include, but are not limited to, home health care, hospice, and physical and occupational therapy; and (F) Complete, sign, and file medical certifications of death, if authorized to do so in the physician assistant's protocol or collaborative agreement; (2) Requires a physician assistant who has not received endorsement from the board to practice under protocols jointly developed by the collaborating physician and the physician assistant; (3) Requires the physician assistant to maintain a copy of the protocols either on paper or electronically at each of the physician assistant's practice locations and make the protocols available upon request by the board, the licensing board of the collaborating physician, or an authorized agent thereof; (4) Requires the protocols to set forth the range of services that may be provided by the physician assistant and must also contain a discussion of the problems and conditions likely to be encountered by the physician assistant and the appropriate treatment for such problems and conditions; (5) Establishes that physician assistant practice under protocols requires active and

the physician assistant and the appropriate treatment for such problems and conditions; (6) Establishes that physician assistant practice under protocols requires active and continuous overview of the physician assistant's activities to ensure that the physician's directions and advice are implemented, but does not require the continuous and constant physical presence of the collaborating physician; (6) Authorizes a physician assistant to perform only those tasks that are within the physician assistant's range of skills and competence, that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of the patients; (7) Requires protocols to also include, at a minimum, the following: (A) The physician assistant's name, license number, and primary practice location; (B) The collaborating physician's name, license number, medical specialty, and primary practice location; (C) A general description of the oversight of the physician assistant by the collaborating physician; (D) A general description of the physician assistant's process for collaboration with physicians and other members of the healthcare team; (E) A process by which 100 percent of patient charts are reviewed by the collaborating physician within 10 days when a prescription for a controlled drug is issued by the physician assistant; (F) A process by which at least 20 percent of the physician assistant's patient charts are reviewed by the collaborating physician every 30 days; (G) If the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which the patient medical charts prepared by the physician assistant are reviewed by the collaborating physician for a minimum of six months or until the physician assistant becomes eligible for endorsement, whichever period is longer; (H) If the physician assistant practices in a remote location site from the collaborating physician's practice site, that the collaborating physician conduct a remote site visit at least every 30 days; (I) That the physician assistant collaborates with, consults with, or refers to, the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care when a patient presents with a condition that is outside of the competence, scope of practice, or experience of the physician assistant or collaborating physician; and (J) Designation of one or more alternative physicians for consultation in situations in which the collaborating physician is not available for consultation; (8) Requires a physician assistant who has received an endorsement from the board to have a collaborative agreement with a physician; (9) Requires the physician assistant to maintain a copy of the collaborative agreement either on paper or electronically at each of the physician assistant's practice locations and make the collaborative agreement available upon request by the board of physician assistants, the licensing board of the collaborating physician, or an authorized agent of such boards; (10) To be eligible to receive endorsement from the board, requires a physician assistant to, at a minimum, have 6,000 hours of documented postgraduate clinical experience, have a physician willing to enter into a collaborative agreement with the physician assistant, and meet such other requirements as set forth in rules promulgated by the board. A physician assistant with 6,000 hours or more of documented postgraduate clinical experience must not practice pursuant to the requirements in state physician assistant law or rules promulgated thereto for endorsed physician assistants without first receiving endorsement by the board. State physician assistant law does not require a physician assistant to become endorsed by the board. Unless a physician assistant has received an endorsement from the board, the requirements under this heading apply; (11) Requires collaborative agreements governing physician assistants who have 6,000 or more hours of documented postgraduate clinical experience and are endorsed by the board to include, at a minimum, the following: (i) the physician assistant's name, license number, and primary practice location; (ii) the collaborating physician's name, license number, medical specialty, and primary practice location; (iii) that the physician assistant performs only those services that are within the physician assistant's competence, knowledge, and skills that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of patients; (iv) a process by which 100 percent of patient charts are reviewed by the collaborating physician within 30 days when a prescription for any drug containing buprenorphine for use in recovery or medication treatment or a Schedule II controlled drug is issued by the physician assistant; (v) that if the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which a sample of patient medical charts prepared by the physician assistant are reviewed by the collaborating physician, or a physician designated by the collaborating physician, for a minimum of six months; (vi) that the physician assistant collaborates with, consults with, or refers to the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care; (vii) methods of communication between the physician assistant and collaborating physician; and (viii) requirements of patient chart review and remote site visits, if any, established at the practice level and commensurate with the level of training, experience, and competence of the physician assistant within the expected scope of practice of the physician assistant; (12) Establishes that, regarding a physician assistant practicing in collaboration with a licensed podiatrist, in addition to meeting the requirements of other relevant state law, the following apply: (i) prohibits providing services that are outside the scope of practice of a podiatrist; (ii) requires complying with the requirements of, and rules adopted pursuant to, the bill and other relevant state law governing the collaboration with a physician assistant; and (iii) authorizes only prescribing drugs that are rational to the practice of podiatry; (13) Authorizes a physician assistant to render emergency medical services in cases where immediate diagnosis and treatment are necessary to avoid patient death or disability; (14) Establishes that the standard of care for a physician assistant is the same standard of care as applicable to a physician who performs the same service; (15) Requires that the initial rules governing the collaboration of physician assistants with licensed physicians be established and promulgated in accordance with the Uniform Administrative Procedures Act, by a task force composed of (i) one member from the board of medical examiners; (ii) one member from the board of osteopathic examination; (iii) one member from the board of podiatric medical examiners; and (iv) three members from the board of physician assistants; (16) Requires the task force to create uniform rules governing the collaboration of physician assistants with licensed physicians, which are binding on each board listed in (15); (17) Requires the rules created by the taskforce to create standard protocols to determine the responsibility for the review of patient medical charts; (18) Requires each board listed in (15) to select and appoint by a majority vote of its members a board member to serve on the task force before September 1, 2024; (19) Requires the task force to select and appoint a member to serve as chair of the task force; (20) Establishes that a majority of the task force constitutes a quorum, and a majority vote of the task force members present is required for any action; (21) Requires the task force to hear public comment at any required hearing on behalf of all boards listed in (15) when a hearing is required. The task force is authorized to vote to promulgate the rules governing the collaboration of physician assistants with licensed physicians for each board listed in (15); (22) Requires the task force to terminate upon the effective date of a permanent rule establishing collaboration pursuant to the bill. All future rules regarding collaboration pursuant to the bill after the termination of the task force must be adopted jointly by each relevant board in (15); (23) Establishes that the bill does not prohibit the licensing boards listed in (15) from promulgating additional rules regarding the licensees of such boards; (24) Requires a licensed physician collaborating with a physician assistant to comply with the following practices: (A) Ensure that protocols or a collaborative agreement, as applicable, is in place for each physician assistant with whom the physician collaborates and that such protocols or collaborative agreement meets the requirements of the bill and the duly promulgated rules. More than one physician may collaborate with the same physician assistant if alternative collaborating physicians are available to collaborate with the physician assistant in the absence or unavailability of the primary collaborating physician. Each physician assistant must notify the board of physician assistants of the name, address, and license number of the physician assistant's primary collaborating physician and notify the board of physician assistants of a change in the primary collaborating physician within 15 days of the change. The number of physician assistants for whom a physician may serve as the collaborating physician must be determined by the physician at the practice level, consistent with good medical practice. The collaborating physician must designate one or more alternate physicians who have agreed to accept the responsibility of collaborating with the physician assistant on a prearranged basis in the collaborating physician's absence; (B) Complete the patient chart reviews of each physician assistant with whom the collaborating physician collaborates as set forth in the bill, in rules promulgated pursuant to the bill, and in protocols or a collaborative agreement, as applicable; (C) Conduct reviews of charts submitted to the collaborating physician by the physician assistant deemed by the physician assistant medically indicated for consultation. The collaborating physician is responsible for reviewing 100 percent of patient charts within 30 days when the physician assistant issues a controlled drug pursuant to protocols. The collaborating physician is responsible for reviewing 100 percent of patient charts within 30 days when the physician assistant issues any drug containing buprenorphine for use in recovery or medication-assisted treatment or a Schedule II controlled drug pursuant to a collaborative agreement; (D) Conduct the requisite remote site visits with each physician assistant with whom the physician collaborates, as set forth in the bill or by rule, and in protocols or a collaborative agreement, as applicable; (E) Each physician assistant must notify the board of the name and address of the physician assistant's primary practice location and notify the board within 15 days of a practice location change; (F) The board of physician assistants is authorized to monitor the prescriptive practices of the physician assistant through site visits by members of the board or their authorized agents; (G) Complaints against physician assistants must be reported to the office of investigations of the division of health related boards; (H) Every prescription order issued by a physician assistant pursuant to the bill must be entered in the medical records of the patient, and every handwritten prescription must be written on a preprinted prescription pad bearing the name, address, and telephone number of the physician assistant, and the physician assistant must sign each prescription order so written; (I) A handwritten prescription order for a drug prepared by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, handwritten in letters or in numerals, instructions for the proper use of the drug and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant must sign the handwritten prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility; (J) A typed or computer-generated prescription order for a drug issued by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription order. The typed or computer-generated prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, recorded in letters or in numerals, instructions for the proper use of the drug, and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant must sign the typed or computer-generated prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility; (K) The bill does not prevent a physician assistant from issuing a verbal prescription order; (L) Handwritten, typed, or computer-generated prescription orders must be issued on either tamper-resistant prescription paper or printed utilizing a technology that results in a tamper-resistant prescription that meets the current centers for medicare and medicaid services guidance to state medicaid directors regarding § 7002(b) of the federal United States Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, and meets or exceeds specific TennCare requirements for tamper-resistant prescriptions; (M) Establishes that (L) does not apply to prescriptions written for inpatients of a hospital, outpatients of a hospital where the doctor or other person authorized to write prescriptions writes the order into the hospital medical record and then the order is given directly to the hospital pharmacy and the patient never has the opportunity to handle the written order, a nursing home or an assisted-care living facility, inpatients or residents of a mental health hospital or residential facility, or individuals incarcerated in a local, state, or federal

correctional facility; (N) A physician assistant authorized to prescribe drugs under the bill who provides services in a free or reduced fee clinic under the Volunteer Health Care Services Act may arrange for required personal review of the physician assistant's charts by a collaborating physician in the office or practice site of the physician or remotely via HIPAA-compliant electronic means rather than at the site of the clinic; (O) A physician assistant authorized to prescribe drugs under the bill who provides services in a community mental health center, or federally qualified health center, or solely via telehealth, may arrange for the required personal review of the physician assistant's charts by a collaborating physician, with the same authority to render prescriptive services that the physician assistant is authorized to render, in the remote office or practice site of the physician, or any required visit by a collaborating physician to any remote site, or both, via HIPAA-compliant electronic means rather than at the site of the clinic; (P) A physician assistant licensed to prescribe drugs who provides services at a remote healthcare setting may arrange for any required personal review of the physician assistant's charts by a collaborating physician either via HIPAA-compliant electronic means or in person; (Q) A physician assistant licensed to prescribe drugs may arrange for up to 10 of the required annual remote site visits by a collaborating physician by HIPAA-compliant electronic means rather than at the site of the clinic. All other of the required site visits by a collaborating physician to a remote site must take place in person at the site of the clinic. As used in this subdivision, "annual" means a rolling twelve-month period; (R) A patient receiving services from a physician assistant must be fully informed that the individual is a physician assistant and a sign must be conspicuously placed within the office indicating that certain services may be rendered by a physician assistant; (S) A physician who does not normally provide patient care must not enter into protocols with, collaborate with, or utilize the services of a physician assistant; (T) A physician assistant must only perform invasive procedures involving a portion of the spine, spinal cord, sympathetic nerves of the spine, or block of major peripheral nerves of the spine in any setting not licensed as a health facility or resource, under the direct supervision of a licensed physician licensed who is actively practicing spinal injections and has current privileges to do so at a licensed facility. The direct supervision provided by a physician in this (T) must only be offered by a physician who meets the qualifications established in state law relative to interventional pain management; (U) For purposes of subdivision (T), "direct supervision" means being physically present in the same building as the physician assistant at the time the invasive procedure is performed; and (V) This (V) does not apply to a physician assistant performing major joint injections, except sacroiliac injections, or to performing soft tissue injections or epidurals for surgical anesthesia or labor analgesia in unlicensed settings; (25) Requires that the board exercise its powers under state law on the grounds of holding oneself out as board-certified in a medical specialty, or utilizing a medical specialty designation with (i) a title or title reference; (ii) an advertisement; (iii) the name of any healthcare setting that is majority-owned by physician assistants; (iv) credentialing with any licensed healthcare facility or health insurance entity; or (v) an application for healthcare liability insurance coverage; (26) Establishes that (25) is not grounds for discipline of a licensee who worked in a healthcare setting that used a medical specialty designation prior to January 1, 2024, as long as: (A) The licensee's collaborating physician (i) is board-certified or board eligible in the designated specialty; (ii) owns part of the practice that provided the services in such healthcare setting; and (iii) sees patients in such healthcare setting on a regular basis; (B) Ownership of the practice has not changed on or after January 1, 2024; (C) Prior to March 1, 2025, a licensee who practices in a healthcare setting described in (26) must submit proof satisfactory to the board that the licensee's healthcare setting meets the requirements of (26); and (D) If a licensee who, prior to March 1, 2025, meets the requirements of (26), ceases to meet such requirements on or after March 1, 2025, then the licensee must notify the board within 30 days; (27) Authorizes the funeral director who first assumes custody of a dead body, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement to sign and file the death certificate. The funeral director, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement must obtain the personal data from the next of kin or the best qualified person or source available, and obtain the medical certification from the person responsible for medical certification; (28) Requires medical certification to be completed, signed, and returned to the funeral director by the physician or physician assistant in charge of the patient's care for the illness or condition that resulted in death within 48 hours after death, except when inquiry is required by the county medical examiner or to obtain a veteran's medical records. In the absence of the physician or physician assistant, the certificate may be completed and signed by another physician designated by the physician, by the chief medical officer of the institution in which the death occurred, or by a physician assistant authorized by protocol or collaborative agreement. In cases of deaths that occur outside of a medical institution and are either unattended by a physician or physician assistant, or not under hospice care, the county medical examiner must investigate and certify the death certificate when one of the following conditions exists: (A) There is no physician or physician assistant who had attended the deceased during the four months preceding death, except that a physician or physician assistant authorized by protocol or collaborative agreement who had attended the patient more than four months preceding death may elect to certify the death certificate if the physician or physician assistant authorized by protocol or collaborative agreement can make a good faith determination as to cause of death and if the county medical examiner has not assumed jurisdiction; or (B) The physician who had attended the deceased during the four months preceding death or physician assistant authorized by protocol or collaborative agreement communicates, orally or in writing, to the county medical examiner that, in the physician's or physician assistant's best medical judgment, the patient's death did not result from the illness or condition for which the physician or physician assistant was attending the patient; (29) If the cause of death cannot be determined within 48 hours after death, requires that the medical certification be completed as provided by rule. The attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement must give the funeral director notice of the reason for the delay, and final disposition of the body must not be made until authorized by the attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement; (30) For purposes of this heading, "referral" means a written or telecommunicated authorization for genetic counseling services from a physician licensed to practice medicine in all its branches or a physician assistant who has protocols or a collaborative agreement with a supervising physician that authorizes referrals to a genetic counselor; (31) Authorizes a physician order for scope of treatment (POST) to be issued by a physician assistant for a patient with whom the physician assistant has a bona fide physician assistant-patient relationship only if, among other conditions, such authority to issue is contained in the physician assistant's protocols or collaborative agreement; (32) Authorizes a POST to be issued by a physician assistant for a patient with whom the physician assistant has a bona fide physician assistant-patient relationship only if, among other conditions, the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available and such authority to issue is contained in the physician assistant's protocols or collaborative agreement, and the physician assistant determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards; (33) Requires that a licensed physician assistant have the same authority that a physician has under this heading to issue certified statements of disability or deafness to accompany the application of disabled or deaf persons to obtain the appropriate registration, license plates, placards and decals from the department, only if the authority is expressly included in the written protocol or collaborative agreement developed jointly by the supervising physician and the physician assistant, setting forth the range of services that may be performed by the physician assistant; (34) Requires the board of medical examiners to establish and maintain an online registry of licensed physicians who are willing to enter into a collaborative agreement with a physician assistant; (35) Requires the online registry to include, at a minimum (i) the physician's name and physical practice address; (ii) designation as a medical doctor or doctor of osteopathy; (iii) the physician's medical specialty and board certifications, if any; (iv) the region or regions of the state in which the physician is willing to enter into a collaborative agreement with a physician assistant; and (v) an address, telephone number, or email address at which the physician can be contacted by a physician assistant who may desire to enter into a collaborative relationship with the physician; (36) Requires a physician included on the registry to update the physician's information described in (35); (37) Establishes that inclusion by a physician on the registry does not obligate a physician to enter into a collaborative agreement with a physician assistant; (38) Prohibits the bill from being construed to prohibit service rendered by a registered nurse, a licensed practical nurse, or a pharmacist pursuant to a collaborative pharmacy practice agreement, if such service is rendered under the supervision, control and responsibility of a licensed physician or to prohibit the provision of anesthesiology services in licensed health care facilities by a dentist licensed in this state who completed a residency program in anesthesiology at an accredited medical school in years 1963 through 1977; and (39) Prohibits the bill from being construed to prohibit service rendered by a physician assistant practicing in collaboration with a physician, osteopathic physician, or podiatrist, whether through protocols or a collaborative agreement.

Fiscal Note: (Dated March 10, 2024) Increase State Revenue $1,094,100/FY24-25/Board of Nursing $189,900/FY24-25/Board of Physician Assistants $328,200/FY25-26 and Subsequent Years/ Board of Nursing $57,000/FY25-26 and Subsequent Years/ Board of Physician Assistants Increase State Expenditures $332,700/FY24-25/ Division of Health-Related Boards $308,900/FY25-26 and Subsequent Years/ Division of Health-Related Boards HB 2318 - SB 2136Pursuant to Tenn. Code Ann. 4-29-121, all health-related boards are required to be self-supporting over a two-year period. The Board of Nursing had an annual surplus of $28,720 in FY21-22, an annual deficit of $665,329 in FY22-23,and a cumulative reserve balance of $7,181,718 on June 30, 2023.The Board of Physician Assistants had an annual surplus of $100,032 in FY21-22, an annual deficit of $29,153 in FY22-23, and a cumulative reserve balance of$295,339 on June 30, 2023.The Division of Health-Related Boards had an annual surplus of $2,687,730 inFY21-22, an annual surplus of $720,811 in FY22-23, and a cumulative reserve balance of $36,563,823 on June 30, 2023.

Senate Status: 04/23/24 - Senate concurred in House amendment 2 (017953).

House Status: 04/22/24 - House passed with amendment 2 (017953).

Executive Status: 04/23/24 - Sent to the speakers for signatures.

SB2138/HB2144 **PROFESSIONS & LICENSURE: Ambulatory surgical treatment centers engaged in the practice of pharmacy.**

Sponsors: Sen. Reeves, Shane , Rep. Martin, Greg

Summary: Allows the board of pharmacy to license ambulatory surgical treatment centers engaged in the practice of pharmacy. Broadly captioned.

Senate Status: 02/01/24 - Referred to Senate Health & Welfare Committee.

House Status: 01/31/24 - Withdrawn in House.

SB2139/HB2358 **HEALTH CARE: Procedure for certain specialty medications to be returned to and re-dispensed.**

Sponsors: Sen. Reeves, Shane , Rep. Carringer, Michele

Summary: Establishes a procedure for specialty medications, defined as prescriptions to treat cancer, symptoms of cancer treatment, and prescriptions for blood and blood components, to be inspected, restocked, and resold if unused by a healthcare provider. If a specialty medication is deemed eligible for restocking by an authorized pharmacy, the pharmacy will reimburse the entity that originally paid for the medication, including TennCare. The authorized pharmacy will maintain records of credits or reimbursements, including specific information about the healthcare provider who returned the medication and other relevant details about the medicine. Additionally, the legislation mandates that drug manufacturers must maintain active commercial general liability insurance to cover any claims related to restocking specialty medication. Individuals acting in good faith in accordance with restocking specialty medication are immune from civil liability and prosecution. Broadly captioned.

Amendment Summary: Senate amendment 2 (015314) rewrites the bill to, instead, do the following: (1) Authorize the board of pharmacy to register any mechanical or electronic systems that operate solely on the premises of a hematology or oncology clinic in this state and that perform the storage, control, and dispensing of commercially-available drug products pursuant to a valid patient-specific prescription, as part of the operations of a licensed pharmacy. The pharmacy responsible for the operations of the mechanical or electronic system must maintain the collection, control, and maintenance of all transaction information and the security, control, and accountability for such commercially-available drug products; (2) Prohibits controlled substances and compounded drug products from being stocked or placed inside such mechanical or electronic system; (3) Prohibits the mechanical or electronic system from engaging in the administration of any drug product; (4) Authorizes only a physician, a nurse, and a pharmacist or pharmacy technician licensed in this state to have access to the mechanical or electronic system as an agent of the patient; (5) Requires the mechanical or electronic system to be stocked only by a pharmacist or a pharmacy intern or pharmacy technician acting under the supervision of a pharmacist; (6) Requires the mechanical or electronic system to be nonmobile in nature and must be placed in a secure location behind a locked door at the hematology or oncology clinic; (7) Requires each patient who receives a commercially-available drug product pursuant to a valid patient-specific prescription from the mechanical or electronic system to receive counseling in accordance with the rules of the board of pharmacy; and (8) Requires the board to establish fees necessary to carry out the bill.

Fiscal Note: (Dated February 28, 2024) NOT SIGNIFICANT

Senate Status: 04/10/24 - Senate passed with amendment 2 (015314).

House Status: 04/22/24 - House passed.

Executive Status: 04/22/24 - Sent to the speakers for signatures.

SB2141/HB2311 **EDUCATION: Availability of opioid antagonists in schools.**

Sponsors: Sen. Reeves, Shane , Rep. Baum, Charlie

Summary: Requires the principal or head of a school that maintains an opioid antagonist at the school to ensure that the opioid antagonist is stored in accordance with manufacturer instructions. Prohibits a school from prohibiting a student, employee, or visitor from possessing an opioid antagonist while the person is on school property or attending a school-sponsored activity held at a location that is not school property.

Fiscal Note: (Dated February 9, 2024) NOT SIGNIFICANT

Senate Status: 03/18/24 - Signed by Senate speaker.

House Status: 03/14/24 - Signed by House speaker.

Executive Status: 04/02/24 - Enacted as Public Chapter 0629 effective March 27, 2024.

SB2176/HB2902 **HEALTH CARE: Removal of the polysomnographic professional standards committee meeting.**

Sponsors: Sen. Hensley, Joey , Rep. Kumar, Sabi

Summary: Removes the requirement for the polysomnographic professional standards committee to conduct at least one meeting each year between the years 2007 and 2010. Broadly captioned.

Amendment Summary: Senate Health and Welfare Committee amendment 1, House amendment 1 (015381) establishes that a minor's parent or guardian may give authorization for all future vaccinations recommended by the minor's healthcare provider, rather than for each individual vaccination. Removes the requirement that a parent or legal guardian of a minor must provide written consent for the vaccination of a minor in the custody of the state. Establishes that a minor's parent or legal guardian who provides consent for all future vaccinations does not have to be present for the administration of a vaccine to the minor, as long as another adult accompanies the minor to the healthcare provider's visit where administration of the vaccine occurs, and that consent for future vaccinations is valid until revoked in writing, including a writing transmitted electronically, by a parent or legal guardian. Does not apply to minors who have been in state custody for a continuous period of time that began prior to the effective date of the legislation and continues through the effective date of the legislation.

Fiscal Note: (Dated January 31, 2024) NOT SIGNIFICANT

Senate Status: 04/15/24 - Withdrawn in Senate.

House Status: 04/24/24 - Re-referred to House Calendar & Rules Committee after adopting 1 (015381).

SB2231/HB2275 **HEALTH CARE: Requirements to qualify for employment as a surgical technologist.**

Sponsors: Sen. Jackson, Ed , Rep. Marsh, Pat

Summary: Replaces the current requirements to qualify for employment as a surgical technologist with successfully completing a nationally accredited surgical technology program recognized by the health facilities commission.

Fiscal Note: (Dated March 14, 2024) NOT SIGNIFICANT

Senate Status: 03/19/24 - Taken off notice in Senate Health & Welfare Committee.

House Status: 03/19/24 - Taken off notice in House Health Subcommittee.

SB2246/HB2093 **HEALTH CARE: Posting of nonresidential buprenorphine guidelines and standards.**

Sponsors: Sen. Swann, Art , Rep. Vaughan, Kevin

Summary: Requires health-related boards that license practitioners authorized to prescribe buprenorphine-containing products to post nonresidential buprenorphine guidelines and standards on the licensing board's website no more than 10 days after receipt of the guidelines. Broadly captioned.

Amendment Summary: House amendment 1 (017307) rewrites the bill to, instead, relative to present law on the use of buprenorphine products, authorize a healthcare provider licensed as a nurse or physician assistant to prescribe a buprenorphine product as approved by the FDA for use in recovery or medication-assisted treatment if the following applies: (1) The provider writes prescriptions of buprenorphine products to 100 or fewer patients at any given time; however, such limit is 250 or fewer patients if the provider practices in a nonresidential office-based opiate treatment facility, as defined in state law, that is accredited by a nationally or internationally recognized accrediting body, including the commission on the accreditation of rehabilitation facilities (CARF) or the joint commission; and (2) When providing direct supervision, as required by state law, the physician does not oversee more than two providers licensed as a nurse or physician assistant at one time during clinical operations; however, if the physician practices in a nonresidential office-based opiate treatment facility that is accredited by a nationally or internationally recognized accrediting body such as CARF or the joint commission, the physician may oversee no more than five providers licensed as nurses or physician assistants, and at no time may the physician oversee the treatment of more than 500 patients under this (2) at any one time during clinical operations.

Fiscal Note: (Dated January 27, 2024) NOT SIGNIFICANT

Senate Status: 04/22/24 - Senate passed.

House Status: 04/16/24 - House passed with amendment 1 (017307).

Executive Status: 04/22/24 - Sent to the speakers for signatures.

SB2253/HB2001 **HEALTH CARE: Extension of time period a provider must send a claimant's medical records.**

Sponsors: Sen. Stevens, John , Rep. Farmer, Andrew

Summary: Extends, from three business days to five business days, the time in which a provider must send a claimant's medical records to a requesting party after receipt of payment for the records.

Amendment Summary: Senate amendment 1 (017483) makes the changes described below to damages in health care liability actions and applies to all health care liability actions filed on or after September 29, 2023. Present law authorizes in a health care liability action in which liability is admitted or established, the damages awarded to include (in addition to other elements of damages authorized by law) actual economic losses suffered by the claimant by reason of the personal injury, including, but not limited to, cost of reasonable and necessary medical care, rehabilitation services, and custodial care, loss of services and loss of earned income, but only to the extent that such costs are not paid or payable and such losses are not replaced, or indemnified in whole or in part, by insurance provided by an employer either governmental or private, by social security benefits, service benefit programs, unemployment benefits, or any other source except the assets of the claimant or of the members of the claimant's immediate family and insurance purchased in whole or in part, privately and individually. This amendment deletes the above present law and, instead, provides that in all health care liability actions, the common law collateral source rule is abrogated as specified in this amendment. In a health care liability action, the damages awarded may include, in addition to other elements of damages authorized by law, past and future actual economic losses suffered by the claimant. Past actual economic losses are limited to the following: (1) The amounts that have been paid or will be paid by the assets of the claimant or on the claimant's behalf; and (2) The amounts the claimant's providers have accepted or will accept as full payment for reasonable and necessary medical care, rehabilitation services, or custodial care, whether pursuant to (i) an agreement with an insurance company or third-party payor; (ii) the authorized reimbursement rates for a government health insurance program in which the claimant and the provider participate; or (iii) any charity, discount program, write-off, gift, or other reason by the provider. This amendment provides that actual economic losses will only be limited to the extent that documentation of the reduction is submitted. As used in this amendment, "actual economic losses" means the financial costs incurred by the claimant by reason of the personal injury, including the cost of reasonable and necessary medical care, rehabilitation services, and custodial care.

Fiscal Note: (Dated February 7, 2024) NOT SIGNIFICANT

Senate Status: 04/11/24 - Senate passed with amendment 1 (017483).

House Status: 04/16/24 - House passed.

Executive Status: 04/16/24 - Sent to the speakers for signatures.

SB2258/HB1710 **HEALTH CARE: Adults suffering from terminal disease - right to die.**

Sponsors: Sen. Campbell, Heidi , Rep. Freeman, Bob

Summary: Creates a process whereby an adult suffering from a terminal disease may request medication for the purpose of ending the adult's life in a humane and dignified manner if certain requirements are met. Broadly captioned. (18pp.)

Fiscal Note: (Dated April 1, 2024) Increase State Expenditures $107,500/FY24-25 and Subsequent Years

Senate Status: 02/01/24 - Referred to Senate Judiciary Committee.

House Status: 01/11/24 - Referred to House Health Committee. House Government Operations will review if recommended.

SB2274/HB2897 **HEALTH CARE: Pharmacy to notify person of lowest available cost of a prescription drug. Broadly captioned.**

Sponsors: Sen. Haile, Ferrell , Rep. Kumar, Sabi

Summary: Requires a pharmacy to make all reasonable effort to contact and notify a person refilling a prescription the lowest available cost of the prescription drug.

Amendment Summary: Senate amendment 1 (015593) rewrites the bill to, instead, establish that a pharmacy or other authorized dispensing person or entity of prescription drugs is encouraged, after a request to fill or renew a prescription drug and prior to the point of sale for such prescription drug, to make reasonable efforts to contact and notify the human patient representative or the person for whom the prescription drug is being filled of the lowest available cost of the prescription drug, including a generic alternative, under a prescription discount or rebate plan, program, or card, or through a different manufacturer, compounder, or supplier, that is available to the person for whom the prescription is being filled through the pharmacy or dispensing person or entity. This amendment provides that if the human patient representative or the person for whom the prescription drug is being filled changes the prescription drug purchase as a result of the notification provided above, then such representative or person must be advised of the effects of purchases made outside of an insurance plan on the deductible status of such plan. This amendment also establishes that a pharmacy or other authorized dispensing person or entity of prescription drugs is immune from civil liability for damages as a result of any act or omission made pursuant to the bill.

Fiscal Note: (Dated February 21, 2024) NOT SIGNIFICANT

Senate Status: 03/25/24 - Senate passed with amendment 1 (015593).

House Status: 04/15/24 - House passed.

Executive Status: 04/15/24 - Sent to the speakers for signatures.

SB2275/HB2907 **HEALTH CARE: Limiting a physician's ability to prescribe medication for themselves and family.**

Sponsors: Sen. Haile, Ferrell , Rep. Kumar, Sabi

Summary: Prohibits a physician from administering a scheduled drug to themselves, or from prescribing, dispensing, or administering medication for immediate family, unless the treatment is minor or in an emergency situation. Prohibits the supervisee of a physician from administering or dispensing medications to a supervising or collaborating physician's immediate family unless it is an emergency situation. Broadly captioned.

Amendment Summary: Senate Health and Welfare Committee amendment 1, House Health Committee amendment 1 (014554) prohibits a physician from prescribing, dispensing, or administering medication for, or otherwise treating, the physician's own self, except in short-term, acute, emergency situations. Prohibits a physician from prescribing, dispensing, or administering medication for, or otherwise treating, immediate family unless such treatment is for minor, self-limited illnesses or acute, emergency situations. Authorizes a physician to treat immediate family members if no other physician offering healthcare services at a location within 30 miles of the physician's primary practice site.

Fiscal Note: (Dated February 7, 2024) NOT SIGNIFICANT

Senate Status: 03/19/24 - Senate Health & Welfare Committee recommended with amendment 1 (014554). Sent to Senate Calendar Committee.

House Status: 04/01/24 - Held on House clerk's desk.

SB2276/HB2904 **HEALTH CARE: Establishes the board of pharmacy and the board of nursing are employees of the department of health.**

Sponsors: Sen. Haile, Ferrell , Rep. Kumar, Sabi

Summary: Establishes the director board of pharmacy and the director board of nursing operate under the supervision and control of the division of health related boards. Establishes that employees of the board of pharmacy and the board of nursing are employees of the department of health. Captioned Broadly.

Fiscal Note: (Dated February 8, 2024) NOT SIGNIFICANT

Senate Status: 03/13/24 - Signed by Senate speaker.

House Status: 03/14/24 - Signed by House speaker.

Executive Status: 04/02/24 - Enacted as Public Chapter 0606 effective March 27, 2024.

SB2292/HB2668 **HEALTH CARE: Changes date annual report treatment for opiate addiction is due.**

Sponsors: Sen. Crowe, Rusty , Rep. Hawk, David

Summary: Changes date that the Mental Health & Substance Abuse Services Department is required to submit an annual report on use of medication-assisted treatment for opiate addiction from February fifteenth to February 1st. Brudly Captioned.

Fiscal Note: (Dated January 31, 2024) NOT SIGNIFICANT

Senate Status: 02/01/24 - Referred to Senate Health & Welfare Committee.

House Status: 02/05/24 - Caption bill held on House clerk's desk.

SB2297/HB2308 **HEALTH CARE: Prescribing a buprenorphine product for the treatment of opioid use disorder.**

Sponsors: Sen. Haile, Ferrell , Rep. Vaughan, Kevin

Summary: Allows for qualifying healthcare providers who work in hospitals, including hospitals exempt from licensure, and an affiliated clinic operating under the hospital’s license to prescribe buprenorphine products. Broadly captioned.

Amendment Summary: Senate amendment 1 (015746) rewrites the bill to, instead, add to present law on the use of buprenorphine products, as follows: (1) Establishes that a licensed physician is the only healthcare provider authorized to prescribe a buprenorphine product for an FDA-approved use in recovery or medication-assisted treatment; (2) Prohibits healthcare providers not licensed as physicians, and who are otherwise permitted to prescribe Schedule II or III drugs, from prescribing a buprenorphine product for the treatment of opioid use disorder unless the provider meets the following criteria: (A) Is licensed and has practiced as a family, adult, or psychiatric nurse practitioner or physician assistant in this state; (B) Has had no limitations or conditions imposed on the provider's license by the provider's licensing authority within the previous three years; (C) Is employed by a hospital that operates with an agreement to train providers from a public or private medical school within this state, or an affiliated clinic operated under the hospital's license, that employs one or more physicians and has adopted clinical protocols for medication-assisted treatment; (D) Is employed at a facility at which healthcare providers are contracted and credentialed with TennCare and TennCare's managed care organizations to treat opioid use disorder with buprenorphine products for use in recovery or medication-assisted treatment; (E) Is employed at a facility at which healthcare providers are accepting new TennCare enrollees or patients for treatment of opiate addiction; (F) Is employed by a facility that requires patients to verify identification; (G) Does not write a prescription for a buprenorphine product that exceeds a 16-milligram daily equivalent; (H) Does not prescribe or dispense a mono product or buprenorphine without naloxone; (I) Works under the supervision of a physician who is actively treating patients with buprenorphine products for recovery or medication-assisted treatment; (J) Prescribes buprenorphine products only to patients who are treated through the organization that employs the provider; (K) Is supervised by or collaborates with a physician who is limited to the supervision of, or collaboration with, a maximum of four licensed nurse practitioners or physician assistants; (L) Is supervised by or collaborates with a physician who reviews 100 percent of the charts of the patients being prescribed a buprenorphine product; (M) Weighs the risk of relapse with the benefit of tapering down or off of buprenorphine when, similar to other disease states, tapering from the treatment medication is clinically appropriate and in agreement with the patient and tapering schedules and durations are patient specific; (N) Initiates and leads a discussion regarding patient readiness to taper down or taper off treatment medications employed in the patient's treatment with each patient at any time upon the patient's request but no later than one year after initiating treatment and then every six months thereafter; (O) Writes prescriptions that can only be dispensed by a licensed pharmacy; and (P) Writes prescriptions of buprenorphine products to 50 or fewer patients at any given time; and (3) Authorizes the health facilities commission to inspect facilities for compliance with the bill and requires the commission to report any violations to the appropriate licensing authority of the provider.

Fiscal Note: (Dated March 8, 2024) NOT SIGNIFICANT

Senate Status: 03/28/24 - Senate passed with amendment 1 (015746).

House Status: 04/15/24 - House passed.

Executive Status: 04/15/24 - Sent to the speakers for signatures.

SB2298/HB2377 **HEALTH CARE: Annual report from department of health regarding data on needle and hypodermic syringe exchange program.**

Sponsors: Sen. Crowe, Rusty , Rep. Terry, Bryan

Summary: Adds the legislative librarian as a party to which the department of health must submit an annual report based on data received by a county or district health department that operates a needle and hypodermic syringe exchange program, including the number of people served, number of needles, syringes, and supplies dispensed and returned to the program, number of naloxone kits distributed, and the number and type of treatment referrals provided. Broadly captioned.

Fiscal Note: (Dated January 30, 2024) NOT SIGNIFICANT

Senate Status: 02/01/24 - Referred to Senate Health & Welfare Committee.

House Status: 02/01/24 - Caption bill held on House clerk's desk.

SB2299/HB2376 **TENNCARE: Annual report on quality and outcomes in perinatal care.**

Sponsors: Sen. Yager, Ken , Rep. Butler, Ed

Summary: Changes from March 1 to January 15 the date by which the bureau of TennCare must submit an annual report to the general assembly concerning aspects of quality and outcomes in perinatal care for the previous two years that includes a description of initiatives by managed care organizations to improve key performance indicators of perinatal care outcomes, and a determination of the effectiveness of managed care organizations' initiatives toward improving perinatal care outcomes to residents in each health region of the state. Broadly captioned.

Amendment Summary: Senate amendment 1 (015674) rewrites the bill to, instead, relative to law regulating health facilities and resources: (1) Define a "home care organization" to mean an organization that provides home health services, home medical equipment services, professional support services, or hospice services to one or more patients on an outpatient basis in either the patient's regular or temporary place of residence. A provider is operating a home care organization if the provider does the following: (A) Holds itself out to the public as providing home health services, home medical equipment services, or hospice services; (B) Contracts or agrees to deliver home health services, home medical equipment services, or hospice services; (C) Accepts physician orders for home health services, home medical equipment services, or hospice services; (D) Accepts responsibility for the delivery of home health services, home medical equipment services, or hospice services; or (E) Contracts to provide professional support services with the state agency financially responsible for services to individuals with mental, intellectual, or developmental disabilities; and (2) Establish that the absence of one or more of the factors in (1) above does not necessarily exclude the provider from the meaning of the definition.

Fiscal Note: (Dated January 30, 2024) NOT SIGNIFICANT

Senate Status: 04/11/24 - Senate passed with amendment 1 (015674).

House Status: 04/16/24 - House passed.

Executive Status: 04/16/24 - Sent to the speakers for signatures.

SB2300/HB2378 **HEALTH CARE: Adds legislative librarian to receiver of a report by the commissioner in supervising dentists and dental equipment.**

Sponsors: Sen. Crowe, Rusty , Rep. Helton-Haynes, Esther

Summary: Adds the legislative librarian as a party to which the commissioner must submit an annual report on the work done by the commissioner in supervising dentists and dental equipment in the various state institutions, as well as in distributing literature throughout the state to inform the public on proper dental care. Broadly captioned.

Amendment Summary: House amendment 1 (016951) rewrites the bill to, instead, establish that one of the powers or duties of the board of nursing is to prescribe the minimum curricular and minimum standards for schools of nursing and for courses of training preparing persons for licensure under state nursing law and provide for surveys of such schools or an affiliation of schools and courses. For practical nursing programs offered by a public institution of higher education, the board must require a minimum of 1,296 clock hours or an equivalent number of credit hours.

Fiscal Note: (Dated January 30, 2024) NOT SIGNIFICANT

Senate Status: 04/11/24 - Senate passed.

House Status: 04/08/24 - House passed with amendment 1 (016951).

Executive Status: 04/11/24 - Sent to the speakers for signatures.

SB2303/HB2573 **TENNCARE: Third-party reimbursement from TennCare for professional services rendered by an employed psychologist.**

Sponsors: Sen. Crowe, Rusty , Rep. Hicks, Gary

Summary: Expands the facilities that can qualify for third-party reimbursement from TennCare, a managed care plan, or a third-party payor for certain services. Expands the number of persons who can render such reimbursable services to an employed psychologist with a provisional or temporary license, psychology intern, and postdoctoral fellow, rather than just for services rendered by a psychologist with a provisional or temporary license. Broadly captioned.

Fiscal Note: (Dated March 30, 2024) NOT SIGNIFICANT

Senate Status: 02/01/24 - Referred to Senate Health & Welfare Committee.

House Status: 02/06/24 - Referred to House Insurance Subcommittee.

SB2328/HB2076 **INSURANCE HEALTH: Recoupment of overpayments made to a healthcare provider.**

Sponsors: Sen. Yager, Ken , Rep. Martin, Brock

Summary: Establishes procedures for recoupment of overpayments made to a healthcare provider by certain health insurance entities. Broadly captioned.

Amendment Summary: Senate amendment 1 (015357) rewrites the bill to, instead, do the following: (1) Establish that a health insurance entity is not required to correct a payment error to a healthcare provider if the provider's request for a payment correction is filed more than 15 months after the date that the healthcare provider received payment for the claim from the health insurance entity; (2) Except in cases of fraud or suspected fraud committed by the healthcare provider, authorize a health insurance entity to only recoup reimbursements made to the provider during the 15-month period after the date that the health insurance entity paid the claim submitted by the healthcare provider; (3) If suspected fraud is not established, authorize a health insurance entity to only recoup reimbursements in accordance with (2) above and (6) below; (4) If a health insurance entity makes a payment pursuant to health insurance coverage issued pursuant to a state employee health plan, authorize the health insurance entity to only recoup reimbursements made to a provider during an eighteen-month period after the date that the health insurance entity paid the claim submitted by the healthcare provider; (5) If a health insurance entity or an agent that contracted to provide eligibility verification verifies that an individual is a covered person, and if the healthcare provider provides services to the individual in reliance on the verification, prohibit the health insurance entity from thereafter recouping a claim on the basis that the individual is not a covered person unless the recoupment occurs within six months of the date that the health insurance entity paid the claim; otherwise, the health insurance entity is barred from making the recoupment unless there was fraud by the healthcare provider. (6) Except in cases of fraud or suspected fraud, require a health insurance entity that intends to recoup a previously paid claim to give the healthcare provider 30 days' advance written or electronic notice specifying the basis for the recoupment, and the notice must contain, at a minimum, the following information: (A) The CPT codes in the claims subject to the recoupment, or, if no CPT code is available, a description of the healthcare items or services for which the health insurance entity intends to recoup reimbursements; (B) A detailed explanation of why the previously made payment is being recouped, including (i) identification of the billing codes and modifiers that the health insurance entity believes should have been billed; and (ii) the health insurance entity's policies supporting the billing codes and modifiers that the health insurance entity believes should have been billed; (C) The claims subject to the recoupment, including applicable claim numbers; (D) The covered person's full legal name and any identification numbers; (E) The dates on which the healthcare provider provided the healthcare items or services, the costs of which are being recouped by the health insurance entity; (F) The estimated amount of recoupment; (G) Each claim's date of payment and how it was issued to the healthcare provider, including by mail or electronically, and, if applicable, the number of the check containing the recoupment or electronic payment identifying information; and (H) The process by which the healthcare provider may appeal the recoupment, including the instructions for the appeal process; (7) If suspected fraud is not established, authorize a health insurance entity to only recoup reimbursements in accordance with (2) and (6) above; (8) If a healthcare provider initiates an appeal within 30 days of the date of a notice of recoupment pursuant to (6) above, prohibit payment from being withheld from the healthcare provider until all appeals are exhausted; (9) Authorize the notice required by (6) above to be included with the results of an audit submitted to a healthcare provider; (10) If the commissioner of commerce and insurance ("commissioner") finds that a health insurance entity has failed to comply with the bill, authorize the commissioner to impose a penalty of two times the amount of the claim or $750, whichever amount is less; (11) In the alternative to (10) above, authorize the healthcare provider to seek injunctive or other appropriate relief in the chancery or circuit court in the county where the provider resides or practices; (12) Establish that the bill must not be waived, voided, or nullified by contract; however, a health insurance entity and a healthcare provider may toll the time periods described in (2)-(5) above through mutually negotiated and separate tolling agreements if both parties agree to toll such time periods; (12) Require that the amount of a recoupment equal the difference between the actual amount paid to a healthcare provider and the amount that should have been paid pursuant to (13) below; (13) Establish that the bill does not interfere with or otherwise repeal (i) the prompt payment appeals process described in state law; (ii) the Prior Authorization Fairness Act; (iii) the authority of a receiver appointed by the commissioner to audit or collect overpayment made to providers more than 18 months from the date that a managed care organization (MCO) paid the claim; (iv) the authority of the bureau of TennCare ("bureau") to collect overpayments made to providers more than 15 months from the date that the MCO paid the claim if discovered and verified by the bureau pursuant to an audit of an MCO; or (v) the subrogation rights or authority of the bureau; (14) Establish that a health insurance entity that contracts directly with the bureau in the provision of services for TennCare recipients is specifically excluded from the bill only for the products and services made by the health insurance entity on behalf of the bureau; (15) Establish that only a health insurance entity or a health insurance entity's agent that contracts with healthcare providers or is responsible for paying contracted or noncontracted healthcare providers may seek to recover payments made to those healthcare providers. No other entity may pursue recoupments governed by the bill; (16) Prohibit a health insurance entity from basing a recoupment on the extrapolation of other claims from an audit; and (17) Authorize the commissioner to promulgate rules to effectuate the bill.

Fiscal Note: (Dated February 19, 2024) Decrease State Revenue $4,211,700/FY24-25 and Subsequent Years Decrease Local Revenue $748,300/FY24-25 and Subsequent Years HB 2076 - SB 2328

Senate Status: 04/08/24 - Senate passed with amendment 1 (015357).

House Status: 04/16/24 - House passed.

Executive Status: 04/16/24 - Sent to the speakers for signatures.

SB2329/HB2354 **COVID-19: Prohibition of mask mandates related to COVID-19.**

Sponsors: Sen. Pody, Mark , Rep. Zachary, Jason

Summary: Prohibits a government entity, school, or local education agency from implementing a mask mandate related to COVID-19 or from requiring an employee of a government entity to wear a face covering as a condition of employment.

Fiscal Note: (Dated March 8, 2024) NOT SIGNIFICANT

Senate Status: 03/27/24 - Taken off notice in Senate State & Local Government Committee.

House Status: 04/03/24 - Taken off notice in House State Government Committee.

SB2351/HB1660 **EDUCATION: Antidiscrimination practices of institutions of higher education.**

Sponsors: Sen. Hensley, Joey , Rep. Ragan, John

Summary: Prohibits certain institutions of higher education from defining discriminatory practices in their antidiscrimination policies in a manner inconsistent with the definition of discriminatory practices in state law. Prohibits certain institutions of higher education from establishing or recognizing forms of discrimination in their antidiscrimination policies in a manner inconsistent with the forms of discrimination recognized as legally actionable by this state. Requires the Tennessee higher education commission to establish a process for persons to file a complaint alleging that an institution is not complying with such prohibitions. Broadly captioned.

Amendment Summary: House Higher Education Subcommittee amendment 1 (015122) requires the Tennessee higher education commission to make rules in consultation with the department of finance and administration, including emergency rules and must be made known in accordance with the Uniform Administrative Procedures Act.

Fiscal Note: (Dated February 3, 2024) Increase State Expenditures $331,800/FY24-25 and Subsequent Years Other Fiscal Impact Federal funding for institutions of higher education could be jeopardized. Additionally, such institutions may incur expenditures associated with litigation. Due to multiple unknown factors such as the future action of the federal government and outcomes of potential ligation, a precise fiscal impact cannot be reasonably determined. Loss of federal student aid funding would result in an unquantifiable recurring increase in state expenditures for last-dollar scholarships provided by the state.

Senate Status: 02/01/24 - Referred to Senate Education Committee.

House Status: 03/11/24 - Failed in House Higher Education Subcommittee after adopting amendment 1 (015122).

SB2359/HB1726 **FAMILY LAW: Prohibits immunization requirement as a condition of adoption or fostering.**

Sponsors: Sen. Watson, Bo , Rep. Gant, Ron

Summary: Prohibits the department of children's services from requiring an immunization as a condition of adopting or overseeing a child in foster care if an individual or member of an individual's household objects to immunization on the basis of religious or moral convictions. Broadly captioned.

Fiscal Note: (Dated February 15, 2024) NOT SIGNIFICANT

Senate Status: 03/27/24 - Signed by Senate speaker.

House Status: 03/28/24 - Signed by House speaker.

Executive Status: 04/25/24 - Enacted as Public Chapter 0699 effective March 25, 2024.

SB2361/HB2213 **INSURANCE HEALTH: Denying coverage of a prescription drug or drug regime based on step therapy protocols.**

Sponsors: Sen. Watson, Bo , Rep. Alexander, Rebecca

Summary: Prohibits a health carrier, health benefit plan, or utilization review organization from using step therapy protocols as a basis to restrict, delay, or deny coverage of a prescription drug or drug regimen for the treatment of cancer or associated conditions if it is consistent with best practices, supported by peer-reviewed evidence-based medical literature, or is approved by the US FDA. Broadly captioned.

Fiscal Note: (Dated February 29, 2024) Increase State Expenditures $3,132,000/FY24-25 and Subsequent Years Increase Federal Expenditures $341,200/FY24-25 and Subsequent Years Increase Local Expenditures $2,029,000/FY24-25 and Subsequent Years*

Senate Status: 03/12/24 - Taken off notice in Senate Commerce & Labor Committee.

House Status: 01/31/24 - Referred to House Insurance Subcommittee.

SB2362/HB2122 **HEALTH CARE: Continuing education for healthcare professionals.**

Sponsors: Sen. Watson, Bo , Rep. Terry, Bryan
Summary: Requires the department to create a continuing education program for the purpose of providing healthcare professionals with information and training relative to public and office safety. Broadly captioned.
Amendment Summary: House amendment 1 (013621) requires the department to make the program available on the board's website within six months of board approval as required by the bill.
Fiscal Note: (Dated February 10, 2024) NOT SIGNIFICANT
Senate Status: 04/08/24 - Signed by Senate speaker.
House Status: 04/04/24 - Signed by House speaker.
Executive Status: 04/22/24 - Signed by governor.

SB2380/HB2554 **PROFESSIONS & LICENSURE: Review of board of pharmacy rules regarding the oversight of facilities that manufacture medical devices.**

Sponsors: Sen. Watson, Bo , Rep. Hazlewood, Patsy
Summary: Requires the board of pharmacy to send notice to the chairs of the government operations committees of the senate and house of representatives within 10 days of the conclusion of the triennial review of board rules regarding the oversight of facilities that manufacture, warehouse, and distribute medical devices performed by an advisory committee that consists of board members. Authorizes the board to send such notice by electronic means. Broadly captioned.
Fiscal Note: (Dated March 30, 2024) NOT SIGNIFICANT
Senate Status: 02/01/24 - Referred to Senate Health & Welfare Committee.
House Status: 02/01/24 - Caption bill held on House clerk's desk.

SB2393/HB2597 **MENTAL HEALTH: Decreasing deadline for filing report on opioid abatement fund.**

Sponsors: Sen. Briggs, Richard , Rep. Baum, Charlie
Summary: Shortens, from September 30 to September 15, the deadline in which opioid fund deposits, abatement strategies, and disbursement or expenses paid from the fund must be reported to executive and legislative branch officials. Broadly captioned.
Fiscal Note: (Dated January 31, 2024) NOT SIGNIFICANT
Senate Status: 03/26/24 - Taken off notice in Senate Judiciary Committee.
House Status: 03/27/24 - Taken off notice in House Finance, Ways & Means Subcommittee.

SB2396/HB2816 **HEALTH CARE: Performing of detransition procedures by gender clinics.**

Sponsors: Sen. Briggs, Richard , Rep. Faison, Jeremy
Summary: Requires gender clinics accepting funds from this state to perform gender transition procedures to also perform detransition procedures. Requires insurance entities providing coverage of gender transition procedures to also cover detransition procedures. Requires certain gender clinics and insurance entities to report information regarding detransition procedures to the department of health. Broadly captioned.
Fiscal Note: (Dated March 4, 2024) Increase State Expenditures $466,300/FY24-25 and Subsequent Years Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. 3-2- 111): Such legislation will result in an increase in the cost of health insurance premiums for procedures and treatments being provided by plans that do not currently offer these benefits at the proposed mandated levels. It is estimated that the increase to each individuals total premium will be less than one percent.
Senate Status: 03/12/24 - Failed in Senate Commerce & Labor Committee.
House Status: 03/13/24 - Taken off notice in House Health Committee.

SB2403/HB2361 **HEALTH CARE: Medical cannabis commission required to have a substance abuse prevention specialist.**

Sponsors: Sen. Briggs, Richard , Rep. Carringer, Michele
Summary: Clarifies that one of the persons appointed to the medical cannabis commission by the speaker of the senate must be a specialist in the area of substance abuse prevention. Broadly captioned.
Amendment Summary: Senate amendment 1 (014509) specifies that the speaker may select from a list rather than requiring the speaker to appoint three members.
Fiscal Note: (Dated February 19, 2024) NOT SIGNIFICANT
Senate Status: 03/07/24 - Senate passed with amendment 1 (014509).
House Status: 02/06/24 - Referred to House Health Subcommittee.

SB2419/HB2445 **TENNCARE: Determining level of funding, medical items, and services received by patient.**

Sponsors: Sen. Crowe, Rusty , Rep. Alexander, Rebecca
Summary: Requires that when deciding on medical necessity, the bureau shall take into consideration the patient's overall condition and use such overall condition as a factor to determine the level of funding and what medical items and services the patient receives, even if such determination does not result in the least costly course of diagnosis or treatment. Broadly captioned.
Fiscal Note: (Dated February 11, 2024) Increase State Expenditures Exceeds $11,125,300/FY24-25 and Subsequent Years Increase Federal Expenditures Exceeds $20,596,000/FY24-25 and Subsequent Years
Senate Status: 04/22/24 - Set for Senate Finance, Ways & Means Committee 04/23/24.
House Status: 04/17/24 - Taken off notice in House Finance, Ways & Means Subcommittee.

SB2466/HB2843 **PROFESSIONS & LICENSURE: Condition for charging fees.**

Sponsors: Sen. Akbari, Raumesh , Rep. Miller, Larry
Summary: Adds as a condition for allowing the board to be able to charge a fee for reviewing and approving prelicensing general contractor education courses that the fee amount is listed on the board's website. Broadly captioned.
Fiscal Note: (Dated February 29, 2024) NOT SIGNIFICANT
Senate Status: 02/01/24 - Referred to Senate Commerce & Labor Committee.
House Status: 02/05/24 - Caption bill held on House clerk's desk.

SB2468/HB2413 **CRIMINAL LAW: Retail sale of marijuana.**

Sponsors: Sen. Akbari, Raumesh , Rep. Dixie, Vincent
Summary: Allows for a person or entity to grow, process, manufacture, deliver, sell, or possess marijuana and can be sold in retail not exceeding an amount of 0.5 oz or 14.175 grams. Also imposes a 12% tax on the retail sale of marijuana. Broadly captioned.
Fiscal Note: (Dated March 28, 2024) Increase State Revenue - $38,299,900/FY24-25/General Fund $77,308,500/FY25-26/General Fund $78,043,400/FY26-27General Fund $78,785,200/FY27-28 and Subsequent Years/General Fund $20,938,800/FY24-25/Educational Purposes $42,275,500/FY25-26/Educational Purposes $42,677,100/FY26-27/Educational Purposes $43,082,500/FY27-28 and Subsequent Years/Educational Purposes $12,563,300/FY24-25/Infrastructure $25,365,300/FY25-26/Infrastructure $25,606,300/FY26-27/Infrastructure $25,849,500/FY24-28 and Subsequent Years/Infrastructure HB 2413 - SB 2468 $300/FY24-25/Secretary of State $100/FY25-26 and Subsequent Years/Secretary of State Increase State Expenditures - $299,700/FY24-25/General Fund $291,300/FY25-26 and Subsequent Years/General Fund Decrease State Expenditures - $143,100/FY24-25 Incarceration $144,500/FY25-26 Incarceration $145,900/FY26-27 and Subsequent Years Incarceration Increase Local Revenue - $9,608,100/FY24-25 $19,398,700/FY25-26 $19,583,000/FY26-27 $19,769,100/FY27-28 and Subsequent Years Decrease Local Expenditures - $12,402,000/FY24-25 and Subsequent Years Other Fiscal Impact This legislation will result in additional state and local tax revenue under the Business Tax Act. Due to variations in the size of separate business entities and the subsequent rate which will be applied to unknown amounts of gross sales of marijuana, exact revenue from this separate tax cannot be determined with reasonable certainty.

Senate Status: 04/02/24 - Taken off notice in Senate Judiciary Committee.
House Status: 02/06/24 - Referred to House Criminal Justice Subcommittee.

SB2588/HB2097 **PROFESSIONS & LICENSURE: Issuance of advisory opinions by state regulatory boards and state health related boards.**

Sponsors: Sen. Taylor, Brent , Rep. Vaughan, Kevin
Summary: Requires state regulatory boards within the department of commerce and insurance to issue advisory opinions upon request to any person who is certified, licensed, or registered by such state entities. Also requires state health related boards within the department of health to issue advisory opinions upon request.
Amendment Senate amendment 1 (015518) requires the commissioner of commerce and insurance, instead of the commissioner of health, to promulgate rules to effectuate the bill.
Summary: House amendment 2 (017335) requires all state entities and programs that are administratively attached to the division of regulatory boards to issue advisory private letter rulings to any affected person who is certified, licensed, or registered by such state entities or under such programs, as applicable, and who makes such a request regarding any matters within the state entities' or under such program's primary jurisdiction. The private letter ruling only affects the person making the inquiry and must have no precedential value for any other inquiry or future contested case to come before the state entity or under such program. Any dispute regarding a private letter ruling may be resolved pursuant to the declaratory order provisions under state law if the board chooses to do so. The division of regulatory boards may prescribe a fee for the issuance of an advisory private letter ruling by rule promulgated in accordance with the bill.
Fiscal Note: (Dated March 8, 2024) NOT SIGNIFICANT
Senate Status: 04/22/24 - Senate concurred in House amendment 2 (017335).
House Status: 04/16/24 - House passed with amendment 2 (017335), which requires all state entities and programs that are administratively attached to the division of regulatory boards to issue advisory private letter rulings to any affected person who is certified, licensed, or registered by such state entities or under such programs, as applicable, and who makes such a request regarding any matters within the state entities' or under such program's primary jurisdiction. The private letter ruling only affects the person making the inquiry and must have no precedential value for any other inquiry or future contested case to come before the state entity or under such program. Any dispute regarding a private letter ruling may be resolved pursuant to the declaratory order provisions under state law if the board chooses to do so. The division of regulatory boards may prescribe a fee for the issuance of an advisory private letter ruling by rule promulgated in accordance with the bill.
Executive Status: 04/22/24 - Sent to the speakers for signatures.

SB2616/HB2869 **HEALTH CARE: Minimum age requirement for membership on the medical cannabis commission.**

Sponsors: Sen. Niceley, Frank , Rep. Terry, Bryan
Summary: Reduces minimum age requirement for membership on the medical cannabis commission from 30 years of age to 25 years of age. Broadly captioned.
Fiscal Note: (Dated February 4, 2024) NOT SIGNIFICANT
Senate Status: 02/05/24 - Referred to Senate Judiciary Committee.
House Status: 03/26/24 - Taken off notice in House Health Subcommittee.

SB2638/HB2367 **COMMERCIAL LAW: Bans pharmaceutical advertisements in newspapers, online, and on TV in this state.**

Sponsors: Sen. Niceley, Frank , Rep. Lynn, Susan
Summary: Prohibits pharmaceutical advertisements in newspapers, online, and on television in this state. Specifies that a violation constitutes a violation of the Consumer Protection Act of 1977. Broadly captioned.
Fiscal Note: (Dated February 12, 2024) NOT SIGNIFICANT
Senate Status: 03/27/24 - Taken off notice in Senate Commerce & Labor Committee.
House Status: 03/19/24 - Taken off notice in House Banking & Consumer Affairs Subcommittee.

SB2738/HB2913 **HEALTH CARE: Removes outdated requirement for submission of apprentice plan.**

Sponsors: Sen. Crowe, Rusty , Rep. Helton-Haynes, Esther
Summary: Removes an outdated requirement that the apprentice plan developed by the boards and commissions of the various medical professions, in consultation with the division of health-related boards, be submitted to the speakers, the government operations committees of the senate and house of representatives, the commissioner of commerce and insurance, the commissioner of health, and the commissioner of labor and workforce development on or before December 31, 2014. Broadly captioned.
Fiscal Note: (Dated February 2, 2024) NOT SIGNIFICANT
Senate Status: 02/05/24 - Referred to Senate Commerce & Labor Committee.
House Status: 02/05/24 - Caption bill held on House clerk's desk.

SB2747/HB2935 **HEALTH CARE: Medical Ethics Defense Act.**

Sponsors: Sen. Haile, Ferrell , Rep. Faison, Jeremy
Summary: Enacts the "Medical Ethics Defense Act," which specifies that a medical practitioner, healthcare institution, or healthcare payer has the right not to participate in or pay for any medical procedure or service which violates the conscience of the medical practitioner, healthcare institution, or healthcare payer, as long as the exercise of this right does not impair the obligations, duties, or responsibilities required of the practitioner, institution, or payer under an existing contract. Specifies that the exercise of the right of conscience is limited to objections to a particular medical procedure or service on the basis of conscience. Clarifies that this section does not waive or modify any duty a medical practitioner, healthcare institution, or healthcare payer may have to provide other medical procedures or services that do not violate the practitioner's, institution's, or payer's conscience. Broadly captioned.
Fiscal Note: (Dated March 31, 2024) NOT SIGNIFICANT
Senate Status: 02/05/24 - Referred to Senate Health & Welfare Committee.
House Status: 02/07/24 - Referred to House Health Subcommittee.

SB2810/HB2622 **HEALTH CARE: Allows the board of pharmacy to license ambulatory surgical treatment centers under certain conditions.**

Sponsors: Sen. Reeves, Shane , Rep. Martin, Greg
Summary: Allows the board of pharmacy to license ambulatory surgical treatment centers that have designated either a pharmacist-in-charge or a medical director licensed as a physician as the person of authority and responsibility for compliance with pertaining laws and rules. Broadly captioned.
Fiscal Note: (Dated February 19, 2024) Increase State Revenue $83,300/FY25-26/Board of Pharmacy $79,000/FY26-27 and Subsequent Years/ Board of Pharmacy Increase State Expenditures $83,300/FY25-26/Board of Pharmacy $79,000/FY26-27 and Subsequent Years/ Board of Pharmacy Pursuant to Tenn. Code Ann. 4-29-121, all health-related boards are required to be self-supporting over a two-year period. The Board of Pharmacy had a surplus of $404,000 in FY21-22, a deficit of $257,521 in FY22-23, and a cumulative reserve balance of $3,259,232 on June 30, 2023.
Senate Status: 03/27/24 - Signed by Senate speaker.
House Status: 03/28/24 - Signed by House speaker.
Executive Status: 04/11/24 - Signed by governor.

SB2812/HB2374 **INSURANCE HEALTH: Information used by health insurance carriers to calculate payments to healthcare providers.**

Sponsors: Sen. Reeves, Shane , Rep. Terry, Bryan
Summary: Requires a health insurance carrier to provide certain information used by the health insurance carrier to calculate payments paid to the healthcare provider within 10 calendar days, rather than 10 business days, of receipt of a written request from a healthcare provider. Broadly captioned.

Amendment Summary: House Insurance Committee amendment 1 (017205) prohibits a health benefit plan or a payer contract from including restrictions on methods of payment from the health insurance issuer or its vendor to the healthcare provider in which the only acceptable payment method is a credit card payment. Requires a health insurance issuer initiating or changing payment methods to a healthcare provider under a payer contract or health benefit plan in order to use electronic funds transfer or credit card payment to (1) notify the healthcare provider if any fees are associated with a particular payment method; (2) advise the healthcare provider of all available methods of payment under the payer contract and provide clear instructions to the provider as to how to select an alternative payment method; and (3) notify the healthcare provider that the healthcare provider can opt out of credit card payments for any services rendered pursuant to the payer contract between the healthcare provider and the health insurance issuer or its vendors, and provide the healthcare provider clear instructions as to how to opt out of such credit card payments. Prohibits a health insurance issuer or its vendor that initiates or changes payments to a healthcare provider through the automated clearinghouse (ACH) network from charging a fee solely to transmit the payment to the provider unless the healthcare provider has consented to the fee. Authorizes a healthcare provider's agent to charge reasonable fees when transmitting an ACH network payment related to transaction management, data management, portal services, and other value-added services. Establishes that violations of the legislation are subject to enforcement by the Commissioner of Commerce and Insurance (DCI).

Fiscal Note: (Dated January 30, 2024) NOT SIGNIFICANT

Senate Status: 03/27/24 - Taken off notice in Senate Commerce & Labor Committee.

House Status: 03/28/24 - Taken off notice in House Calendar & Rules Committee.

SB2818/HB2446 **HEALTH CARE: Notice from board of pharmacy regarding drugs deemed misbranded or adulterated.**

Sponsors: Sen. Reeves, Shane , Rep. Alexander, Rebecca

Summary: Extends from 10 to 14 days the period following receipt of notice from the board of pharmacy within which an owner or person in possession of drugs or devices that have been deemed misbranded or adulterated must request a show cause hearing before the board on the applicability of the adulterated drug or device statute. Broadly captioned.

Fiscal Note: (Dated January 31, 2024) NOT SIGNIFICANT

Senate Status: 03/12/24 - Taken off notice in Senate Commerce & Labor Committee.

House Status: 02/01/24 - Caption bill held on House clerk's desk.

HJR42 **JUDICIARY: Constitutional amendment - proposing of laws by initiative.**

Sponsors: Rep. Hardaway, G.A.

Summary: Proposes an amendment to allow people to propose laws by initiative.

House Status: 03/13/24 - Failed in House Elections & Campaign Finance Subcommittee.

HJR82 **HEALTH CARE: Constitutional amendment - establishes a medical cannabis program.**

Sponsors: Rep. Powell, Jason

Summary: Proposes an amendment to the Constitution of Tennessee to establish a medical cannabis program.

House Status: 03/26/24 - Failed in House Health Subcommittee.