## OLR Bill Analysis

## sHB 5514 (as amended by House "A")*

### *AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.*

TABLE OF CONTENTS:

SUMMARY

§ 1 — HEALTH CARE FACILITIES OPERATED BY EDUCATIONAL FACILITIES

*Allows an infirmary operated by an educational institution to care for dependent family members of students, faculty, and employees when they are enrolled in the institution's health plan*

§ 2 — WORKING GROUP ON MANAGED RESIDENTIAL COMMUNITIES

*Requires the DPH commissioner to establish a working group to advise the department on managed residential communities in the state that provide assisted living services and whether these communities should be licensed by the state*

§ 3 — NONPROFIT DISTRIBUTION OF FREE EYEGLASSES

*Allows nonprofits that give free eyeglasses to give them to the person's authorized representative if the person is unavailable to receive them from the organization in-person*

§ 4 — PATIENT NOTICE ON MEDICAL RECORDS RETENTION

*Requires health care providers to notify patients in writing at their initial intake about the amount of time the law requires the provider to keep their medical records and how the patient can request copies of them*

§§ 5-7 — TECHNICAL CHANGES

*Makes technical changes to update the name of LeadingAge Connecticut to Leading Age Connecticut and Rhode Island in statute*

§ 8 — SEWAGE DISPOSAL AND NITROGEN REMOVAL

*Requires the DPH and DEEP commissioners, by July 1, 2028, to consult with nitrogen removal experts to establish procedures and standards for reviewing and approving new nitrogen removal technologies for DPH-regulated subsurface sewage disposal systems*

§ 9 — TEMPORARY VETERINARY PERMITS

*Under specified conditions, allows DPH to issue a temporary veterinarian permit to graduates of foreign veterinary schools, allowing them to work under direct supervision of certain state-licensed veterinarians*

§ 10 — VETERINARY TELEHEALTH WORKING GROUP

*Creates a working group to evaluate the feasibility of establishing a veterinary-client-patient-relationship through telehealth*

## § 11 — HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENTS

*Requires hospitals, when conducting a community health needs assessment, to (1) consider including the nutritional needs of community members with diabetes and congestive heart failure and (2) include these community members' nutrition needs in their assessment to the extent federal law allows*

## § 12 — BRIDGE PROGRAM FOR EMERGENCY OPIOID USE DISORDER TREATMENT

*Generally allows hospitals to (1) administer buprenorphine or methadone to someone who comes to the emergency department with symptoms of opioid use disorder without requiring them to be admitted; (2) offer these patients an opioid antagonist prescription when discharged and refer them to outpatient care; and (3) give these patients, when discharged, either a bridging dose or last dose letter (depending on the medication)*

## § 13 — ENDOMETRIOSIS WORKING GROUP

*Establishes a 20-member endometriosis working group in the Legislative Department to evaluate and make recommendations on endometriosis diagnosis, treatment, research, education, and public awareness*

## § 14 — ADVISORY COUNCIL ON CHIMERIC ANTIGEN RECEPTOR T-CELL THERAPY

*Establishes a 20-member advisory council on CAR T-cell therapy to advise and make recommendations to DPH and other state agencies related to these therapies; requires the council to report annually to the Insurance and Real Estate and Public Health committees*

## §§ 15-17 — ATHLETIC HEALTH ASSESSMENTS FOR HIGH SCHOOL STUDENT ATHLETES

*Generally requires public high school students, before playing interscholastic sports, to have an annual athletics health assessment to screen for serious cardiac conditions*

## § 18 — MENOPAUSE PROVIDER TOOLKIT

*Requires UConn's Health Disparities Institute to (1) develop a menopause toolkit for specified providers who diagnose or treat people with symptoms of menopause, perimenopause, and post-menopause; (2) distribute the toolkit to providers by June 1, 2028; and (3) distribute a revised toolkit by January 1, 2029, based on provider feedback*

## §§ 19-22 — SCHOOL SAFETY PLANS

*Sets requirements for health care providers to share certain minors' safety plans with schools*

## §§ 23, 24 & 27 — NURSE'S AIDES

*Starting in October 2027, expands DPH's nurse's aide registry to include nurse's aides working at any DPH-licensed health care institution, rather than just nursing homes as under current law, and makes related changes to expand DPH's authority to take disciplinary action against nurse's aides who commit specified misconduct*

## §§ 25 & 26 — RURAL HEALTH TRANSFORMATION PROGRAM

*Allows DPH to take disciplinary action against a practitioner for failing to fulfill any material obligation resulting from the receipt of funding from DPH under the federally-funded Rural Health Transformation program; exempts program funding to the tribes from the general requirement that they first adopt an Employment Rights Code before the state can provide funds that assist a tribe engaged in a commercial enterprise*

§§ 28-30 — EMS LICENSURE INTERSTATE COMPACT AND BACKGROUND CHECKS

*Enters Connecticut into the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact, no earlier than one year after a neighboring state enters it; correspondingly requires DPH to institute a criminal background check requirement for EMS personnel (starting one year after a neighboring state enters the compact); requires DPH to report on the compact's implementation within five years after the state enters it*

§ 31 — WELL WATER TESTING RESULTS

*Allows health authorities to disclose private residential or semipublic well testing results to eligible parties without getting the DPH commissioner's approval, and expands the allowable recipients to include certain nearby property owners*

§ 32 — STATE EXTREME WEATHER PROTOCOLS

*Requires (1) DESPP to develop guidance on extreme hot and cold weather protocols and improvements to public communication of these protocols and (2) DOH to develop ways to improve outreach to unhoused people during extreme weather events*

§§ 33-36 — DENTISTS

*Under certain conditions, allows dentists to administer cosmetic injections on patients' faces; eliminates the requirement that dentists remain on-site when delegating to dental assistants the taking of dental x-rays; adds to the list of topics from which dentists must select for certain hours of continuing education*

§ 37 — REPEALERS

*Repeals the statutory cap on executive director salaries in state agencies' calculations of grants to private agencies that provide employment opportunities, day services, or residential facility services*

## SUMMARY

This bill makes various unrelated changes to the public health statutes as shown in the section-by-section analysis below.

*House Amendment "A" replaces the original bill (File 540) and adds provisions on (1) nitrogen removal technologies for certain subsurface sewage disposal systems, (2) temporary veterinary permits, (3) a veterinary telehealth working group, (4) hospital community health needs assessments, (5) a bridge program for emergency opioid use disorder treatment, (6) an endometriosis working group, (7) an advisory council on CAR T-cell therapy, (8) athletic health assessments for high school student athletes, (9) a menopause provider toolkit, (10) student safety plans, (11) nurse's aides, (12) the Rural Health Transformation program, (13) the Emergency Medical Services (EMS) Personnel Licensure Interstate Compact and EMS background checks, (14) well water testing results, (15) state extreme weather protocols, and (16)

dentists (including the administration of cosmetic injections).

It also eliminates provisions on (1) Department of Developmental Services (DDS) abuse and neglect reports, (2) sewage disposal working group recommendations, and (3) nursing school data reporting.

EFFECTIVE DATE: October 1, 2026, unless otherwise noted below.

## § 1 — HEALTH CARE FACILITIES OPERATED BY EDUCATIONAL FACILITIES

*Allows an infirmary operated by an educational institution to care for dependent family members of students, faculty, and employees when they are enrolled in the institution's health plan*

The bill allows an infirmary operated by an educational institution to provide care to dependent family members of students, faculty, and employees when these family members are enrolled in the institution's health plan.

Under current state law and regulation, these facilities provide evaluation and treatment for routine health problems and, in some cases, short-term overnight accommodations (for example, when someone is recovering from surgery or requires observation) only for students, faculty, and employees (Conn. Agencies Regs., § 19-13-D43a(a)(15)).

## § 2 — WORKING GROUP ON MANAGED RESIDENTIAL COMMUNITIES

*Requires the DPH commissioner to establish a working group to advise the department on managed residential communities in the state that provide assisted living services and whether these communities should be licensed by the state*

The bill requires the Department of Public Health (DPH) commissioner to establish a working group to advise the department on (1) managed residential communities (MRCs) where assisted living services agencies (ALSAs) provide services to residents and (2) whether licensing these MRCs would enable DPH and these communities to improve residents' health, safety, and overall well-being.

Under the bill, the working group must at least include:

1. at least three representatives each of different MRCs and ALSAs

in the state;

2. at least three residents and three relatives of residents receiving assisted living services in an MRC, each from different communities; and

3. one representative of a state association of aging services organizations.

The bill requires the working group to report its findings and recommendations to the DPH commissioner by January 1, 2027. The commissioner must then report the information to the Public Health Committee by February 1, 2027, and indicate whether she agrees with each finding and recommendation.

EFFECTIVE DATE: July 1, 2026

### *Background — MRCs*

By law, the state does not license assisted living facilities. Instead, it licenses and regulates ALSAs that provide assisted living services. ALSAs can only provide these services at an MRC. MRCs that wish to provide assisted living services must obtain a DPH license as an ALSA or arrange for the services with a licensed ALSA.

## § 3 — NONPROFIT DISTRIBUTION OF FREE EYEGLASSES

*Allows nonprofits that give free eyeglasses to give them to the person's authorized representative if the person is unavailable to receive them from the organization in-person*

Regardless of the state's optician laws, the bill allows nonprofit organizations that give free glasses produced by an optician to the person wearing them to give the glasses to the wearer's authorized representative if the wearer is unavailable to receive them in-person from the organization.

Under current practice, the Connecticut Board of Examiners for Opticians requires eyeglasses to be dispensed in-person by a licensed optician.

EFFECTIVE DATE: July 1, 2026

## § 4 — PATIENT NOTICE ON MEDICAL RECORDS RETENTION

*Requires health care providers to notify patients in writing at their initial intake about the amount of time the law requires the provider to keep their medical records and how the patient can request copies of them*

The bill requires health care providers, starting by January 1, 2027, to notify patients in writing at their initial intake, about the amount of time the law requires the provider to keep their medical records and how the patient can request copies of them.

## §§ 5-7 — TECHNICAL CHANGES

*Makes technical changes to update the name of LeadingAge Connecticut to Leading Age Connecticut and Rhode Island in statute*

The bill makes technical changes to statutory provisions referencing Leading Age CT, updating its name to Leading Age Connecticut and Rhode Island to reflect the merging of its Connecticut and Rhode Island associations.

EFFECTIVE DATE: Upon passage

## § 8 — SEWAGE DISPOSAL AND NITROGEN REMOVAL

*Requires the DPH and DEEP commissioners, by July 1, 2028, to consult with nitrogen removal experts to establish procedures and standards for reviewing and approving new nitrogen removal technologies for DPH-regulated subsurface sewage disposal systems*

The bill requires the DPH and Department of Energy and Environmental Protection (DEEP) commissioners, by July 1, 2028, to consult with nitrogen removal experts to do the following:

1. determine nitrogen credit equal to the nitrogen credit values for DEEP-approved nitrogen removal technologies that are published before July 1, 2028, in the technical standards for on-site sewage disposal systems under DPH jurisdiction;

2. determine nitrogen credit equal to the nitrogen credit values for DEEP-approved nitrogen removal technologies that are not published in the technical standards before this date that meet the definition of subsurface sewage disposal systems in state regulation; and

3. establish procedures and standards for reviewing and approving

new nitrogen removal technologies, with the procedures and standards supported by independent third-party testing and climate-relevant field data demonstrating the technology's effectiveness in removing nitrogen.

The bill requires the DPH commissioner to (1) adopt implementing regulations and (2) publish specifications for nitrogen removal technologies approved according to the procedures and standards described above in the technical standards.

Under the bill, "nitrogen removal technology" is a system that removes nitrogen used in subsurface sewage disposal systems delegated to DPH (see *Background — DPH Sewage Disposal Oversight*), except for alternative on-site sewage treatment systems with daily capacities of up to 10,000 gallons.

EFFECTIVE DATE: Upon passage

### *Background — DPH Sewage Disposal Oversight*

PA 23-207 transferred regulatory authority from DEEP to DPH over small community sewerage systems and household and small commercial subsurface sewage disposal systems with daily capacities of up to 10,000 gallons. By law, the DEEP commissioner must post notice of her intent to amend the regulations to effectuate this transfer on the eRegulations system by July 1, 2026. Before amending the regulations, she must consider the recommendations of a sewage disposal working group established under PA 25-97.

## § 9 — TEMPORARY VETERINARY PERMITS

*Under specified conditions, allows DPH to issue a temporary veterinarian permit to graduates of foreign veterinary schools, allowing them to work under direct supervision of certain state-licensed veterinarians*

The bill allows DPH to issue a temporary veterinary permit to someone who (1) graduated from a veterinary school (see below) located outside of the U.S., its territories, or Canada and (2) is working toward certification from the Educational Commission for Foreign Veterinary Graduates (ECFVG) or Program for the Assessment of Veterinary Education Equivalence. For the person to be eligible, the

veterinary school program must be one that the American Veterinary Medical Association finds acceptable for ECFVG certification.

The bill allows a permit holder to practice only under the direct supervision of a veterinarian who has been licensed in the state for at least two years. "Direct supervision" means the licensed veterinarian is in the office where the permit holder is practicing and immediately available to help and direct the permit holder.

The permit is valid for up to two years and can be renewed once (for two years) if the applicant fails to get certification from the commission or program specified above during the initial two-year period. There is no permit fee.

### *Background — Related Bill*

sSB 190, § 1 (File 27), favorably reported by the Public Health Committee, contains similar provisions on temporary veterinary permits for graduates of foreign schools.

## § 10 — VETERINARY TELEHEALTH WORKING GROUP

*Creates a working group to evaluate the feasibility of establishing a veterinary-client-patient-relationship through telehealth*

The bill creates a working group within the Legislative Department to (1) evaluate whether it is feasible to allow a veterinarian-client-patient relationship to be created through telehealth when an animal needs medical care or treatment and (2) if so, make related recommendations. By January 1, 2027, the working group must report to the Public Health Committee on its evaluation and recommendations. (Under existing law, a veterinarian-client-patient relationship cannot be established through telehealth, but after an initial in-person appointment, veterinarians generally may use telehealth if it is not medically necessary for them to examine the animal in-person.)

The working group's membership includes the Public Health Committee chairpersons and ranking members, or their designees, and four members appointed by the chairs and ranking members, as follows:

1. two members of an in-state veterinarian association, one each

appointed by the Public Health Committee's Senate chairperson and House ranking member; and

2. two proponents of creating a veterinarian-client-patient relationship through telehealth when an animal needs medical care or treatment, one each appointed by the committee's House chairperson and Senate ranking member.

Under the bill, the Public Health Committee's administrative staff serves in that capacity for the working group.

EFFECTIVE DATE: Upon passage

### *Background — Related Bill*

sSB 190, § 2 (File 27), favorably reported by the Public Health Committee, allows a veterinarian-client-patient relationship to be established through telehealth under specified conditions.

## § 11 — HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENTS

*Requires hospitals, when conducting a community health needs assessment, to (1) consider including the nutritional needs of community members with diabetes and congestive heart failure and (2) include these community members' nutrition needs in their assessment to the extent federal law allows*

The bill requires hospitals, when conducting a community health needs assessment, to consider including the nutritional needs of community members with diabetes and congestive heart failure, if warranted by available data. They must also, to the extent federal law allows, include these community members' nutrition needs in their assessment.

To maintain tax-exempt status under federal law, a nonprofit hospital must, among other things, (1) conduct a community health needs assessment at least once every three years and (2) adopt an implementation strategy to meet the needs identified in the assessment. Federal regulations set various steps that hospitals must take in completing these requirements (26 C.F.R. § 1.501(r)-3).

### *Background — Related Bill*

sSB 239 (File 31), favorably reported by the Public Health Committee,

requires hospitals, when conducting a community health needs assessment, to examine the nutritional needs of community members with diabetes and congestive heart failure.

## § 12 — BRIDGE PROGRAM FOR EMERGENCY OPIOID USE DISORDER TREATMENT

*Generally allows hospitals to (1) administer buprenorphine or methadone to someone who comes to the emergency department with symptoms of opioid use disorder without requiring them to be admitted; (2) offer these patients an opioid antagonist prescription when discharged and refer them to outpatient care; and (3) give these patients, when discharged, either a bridging dose or last dose letter (depending on the medication)*

Starting January 1, 2027, the bill allows hospitals, if federal law allows, to administer buprenorphine or methadone to a patient who presents to the emergency department with symptoms of opioid use disorder without requiring the patient to be admitted solely to do so. Under the bill, hospitals may do this only if administering the medication is medically indicated and the patient consents to it.

Additionally, the bill allows hospitals, if federal law allows, to (1) offer these patients a prescription for or a supply of an opioid antagonist (for example, Narcan) when they are discharged from the emergency department (and provide it if they accept the offer) and (2) refer them to community providers or opioid treatment programs that can provide continuity in prescribing buprenorphine or administering methadone. If clinically indicated, hospitals may also give patients a supply of methadone, in compliance with federal regulations on prescribing controlled substances.

Under the bill, hospitals must, if federal law allows, give patients administered buprenorphine a bridging prescription for the medication to cover the anticipated time during which they are waiting to be seen by their referred community provider. For patients given methadone, hospitals must give them a last-dose letter to give to their referred treatment program. (A “last-dose letter” is a formal, sealed document that confirms the exact date, time, and amount of the patient’s last methadone dose.)

The bill specifies that it does not (1) require providers to give these medications when medically contraindicated, (2) limit a treating

clinician's ability to exercise professional judgement, or (3) prevent the use of other medications to treat opioid use disorder when it is clinically appropriate and the patient consents to it.

Under the bill, "community providers" are health care providers allowed by federal and state law to prescribe buprenorphine to treat opioid use disorder. "Opioid treatment programs" are those certified by the federal Substance Abuse and Mental Health Services Administration and allowed by state and federal law to administer methadone to treat these disorders.

### *Background — Related Bill*

sSB 365 (File 157), favorably reported by the Public Health Committee, requires hospitals to administer buprenorphine or methadone to a patient who presents to the emergency department with symptoms of opioid use disorder under similar conditions as this bill.

## § 13 — ENDOMETRIOSIS WORKING GROUP

*Establishes a 20-member endometriosis working group in the Legislative Department to evaluate and make recommendations on endometriosis diagnosis, treatment, research, education, and public awareness*

The bill establishes a 20-member endometriosis working group within the Legislative Department to evaluate and make recommendations on endometriosis diagnosis, treatment, research, education, and public awareness in Connecticut.

The bill requires the working group, starting by January 1, 2027, to annually report to the governor and the Human Services and Public Health committees on its evaluation and recommendations, including any legislation needed to implement them.

EFFECTIVE DATE: Upon passage

### *Evaluation*

The bill requires the working group to evaluate the following:

1. the prevalence and impact of endometriosis in Connecticut;

2. barriers to timely and accurate diagnosis;

3. access to evidence-based treatments, such as medical, surgical, and therapeutic interventions;

4. insurance coverage and reimbursement practices for treating the condition;

5. the condition's impact in the workplace, including leave, accommodations, and employment protections;

6. gaps in public and provider education and training; and

7. opportunities to improve data collection, research, and patient outcomes.

### *Membership*

Under the bill, the working group's membership includes the (1) insurance and public health commissioners or their designees and (2) co-chairpersons of the state's endometriosis data and biorepository program (see *Background – Endometriosis Data and Biorepository Program*). It also includes the following 16 appointed members listed in the table below:

**Table: Endometriosis Working Group Appointed Members**

| *Appointing Authority* | *Member Qualifications* |
|---|---|
| House speaker (4) | • One House member<br>• One Connecticut-licensed physician experienced in diagnosing and treating endometriosis<br>• One representative of a federally qualified health center<br>• One state resident diagnosed with endometriosis |
| Senate president pro tempore (4) | • One Senate member<br>• One physician member of the American College of Obstetrics and Gynecology<br>• One researcher affiliated with a Connecticut academic or research institution with expertise in endometriosis<br>• One patient advocate with experience advocating on behalf of people with endometriosis |
| House minority leader (4) | • One House member<br>• One pediatric or adolescent medicine physician currently practicing in the state<br>• One expert in racial and health equity or representative of a community-based organization serving historically |

| Appointing Authority | Member Qualifications |
|---|---|
| | underserved populations<br>• One representative of a state hospital association or a Connecticut hospital administrator |
| Senate minority leader (4) | • One Senate member<br>• One representative of a school-based health center<br>• One representative of a therapeutic or drug manufacturer experienced in endometriosis-related treatments<br>• One state resident diagnosed with endometriosis |

The bill staggers appointed members' terms (except for legislators) as determined by the Commission on Women, Children, Seniors, Equity and Opportunity's (CWCSEO) executive director, with six initial appointees serving a two-year term, and the other six serving a three-year term. After that, members serve two-year terms and may be reappointed.

The bill requires appointing authorities to make initial appointments within 30 days after the bill's passage and fill any vacancy within 30 days.

Under the bill, members serve without compensation but may be reimbursed for their necessary expenses in performing their duties.

### *Meetings and Leadership*

CWCSEO's executive director must schedule and hold the first meeting within 60 days after the bill's passage. The working group must appoint a chairperson and vice-chairperson from among its members at the first meeting.

Under the bill, the working group must meet at least quarterly and provide opportunities for public comment at the meetings.

The bill requires the CWCSEO administrative staff to serve in this capacity for the working group.

### *Background — Endometriosis Data and Biorepository Program*

In 2023, the legislature directed UConn Health and The Jackson Laboratory to create an endometriosis data and biorepository program

to promote research on (1) early detection of endometriosis in adolescents and adults and (2) developing therapeutic strategies to improve clinical management of the condition. The program, EndoRISE, focuses on administering the endometriosis biorepository, public awareness, and clinical education.

### *Background — Related Bill*

sHB 5322 (File 514), favorably reported by the Public Health Committee, contains identical provisions on an endometriosis working group.

## § 14 — ADVISORY COUNCIL ON CHIMERIC ANTIGEN RECEPTOR T-CELL THERAPY

*Establishes a 20-member advisory council on CAR T-cell therapy to advise and make recommendations to DPH and other state agencies related to these therapies; requires the council to report annually to the Insurance and Real Estate and Public Health committees*

The bill establishes a 20-member advisory council on chimeric antigen receptor (CAR) T-cell therapy and other gene therapies within DPH for administrative purposes only. Under the bill, the advisory council must advise and make recommendations to DPH and other state agencies related to these therapies, such as on (1) how to deliver them in a safe, equitable, and financially sustainable way; (2) developing related referral and management protocols; and (3) advanced training for clinical providers who offer them.

The bill authorizes the council to (1) apply for and accept grants, gifts, bequests, sponsorships, and in-kind donations from federal and interstate agencies, private firms, individuals, and foundations to carry out its responsibilities and (2) enter into a contract or agreement needed to distribute or use any received funds, services, or property according to any conditions placed on them.

Lastly, the bill requires the council to annually report to the Insurance and Real Estate and Public Health committees on its findings and recommendations, including (1) its activities, research findings, and recommended legislative proposals and (2) potential funding sources for its activities, including grants, donations, sponsorships, or in-kind donations. The first report is due no later than one year after the date of

the council’s first meeting.

EFFECTIVE DATE: July 1, 2026

### *Advisory Council Responsibilities*

The bill requires the council to advise and make recommendations to DPH and other state agencies on the following:

1. the availability of CAR T-cell therapy and other gene therapies in Connecticut to treat cancer;

2. how to deliver these therapies in a safe, equitable, and financially sustainable way;

3. advanced training for clinical providers who offer these therapies;

4. long-term follow-up and vector safety (mitigating unintended harm from viruses used in gene therapy) for patients receiving these therapies;

5. developing referral and management protocols for these therapies;

6. education on these therapies and protocols for clinicians, patients, and patients’ relatives and caregivers;

7. advising patients and their relatives and caregivers on the cost and available insurance coverage for these therapies;

8. opportunities to coordinate with research collaborations, government agencies (for example, the Centers for Medicare and Medicaid Services), accrediting bodies, and national registries on these therapies;

9. developing centers of excellence in Connecticut to deliver these therapies, including requiring centers to be accredited;

10. developing a statewide referral network to ensure all patients are matched with a Connecticut center of excellence;

11. developing safety protocols to address patient complications and other safety concerns;

12. ways to provide psychosocial support to patients and their relatives and caregivers; and

13. ways to track patient outcomes, focusing on equity related to diagnosis, race, ethnicity, geography, and income.

### *Functions*

In doing its work, the bill authorizes the advisory council to do the following:

1. consult with experts on CAR T-cell therapy and other gene therapies to treat cancer to develop policy recommendations for improving access to these therapies in Connecticut;

2. hold public hearings and otherwise make public inquiries and solicit public comments to help with a study or survey of people living with cancer who received these therapies, these patients' caregivers, health care providers, and patient advocates; and

3. conduct research and make recommendations to DPH and other state agencies.

### *Membership*

Under the bill, the advisory council's membership includes the following state officials, or their designees: (1) the insurance, public health, and social services commissioners and (2) the health information technology officer. The council also includes the following 16 appointed members as shown in the table below.

**Table: Appointed Council Members Under the Bill**

| *Appointing Authority* | *Member Qualifications* |
|---|---|
| Public Health Committee Senate chairperson (4) | • One hematologist or oncologist serving adults<br>• One specialist in emerging cellular and genetic therapy<br>• One pharmacology expert<br>• One patient advocate for conditions treated by gene therapy |

| Appointing Authority | Member Qualifications |
|---|---|
| Public Health Committee House chairperson (4) | • One patient who received CAR T-cell therapy<br>• One representative of a Connecticut hospital association<br>• One pediatric hematologist or oncologist<br>• One community health equity advocate |
| Public Health Committee Senate ranking member (4) | • One representative of an internationally recognized accreditation body for institutions providing cellular therapies<br>• One representative of a Connecticut health carrier association<br>• One director of a Connecticut cellular therapy program<br>• One representative of the life sciences or biotechnology industries |
| Public Health Committee House ranking member (4) | • One representative, family member, or caregiver of someone living with cancer who received gene therapy<br>• One advocate for cancer patients in the state<br>• One social worker or patient navigator<br>• One director of a transplant and cellular therapy program in the state |

The bill requires appointing authorities to make their initial appointments by October 31, 2026, and fill any vacancies. Members serve three-year terms, except for those representing state agencies.

The DPH commissioner must choose the council's acting chairperson to organize its first meeting, which must be scheduled and held by November 30, 2026. At the first meeting, council members must appoint their chairperson and vice chairperson by a majority vote. The bill requires the council to meet at least quarterly, either in person or remotely, as the chairperson determines.

Under the bill, members are not compensated, but may be reimbursed for necessary expenses incurred in performing their duties.

### Background — CAR T-cell therapy

CAR T-cell therapy is an individualized immunotherapy that genetically changes a person's own T-cells to recognize and fight cancer cells. It is often used to treat blood cancers such as leukemia, lymphoma, and multiple myeloma.

### Background — Related Bill

SB 451 (File 566), favorably reported by the Public Health Committee,

has similar provisions on a CAR T-cell therapy advisory council.

## §§ 15-17 — ATHLETIC HEALTH ASSESSMENTS FOR HIGH SCHOOL STUDENT ATHLETES

*Generally requires public high school students, before playing interscholastic sports, to have an annual athletics health assessment to screen for serious cardiac conditions*

Starting in the 2027-28 school year, the bill generally requires public high school students, before participating in interscholastic sports, to have an annual athletics health assessment by a health professional. This must include a physical exam that screens for serious cardiac conditions that could lead to sudden death. Among other things, the assessment form must include information on relevant patient or family history and whether the provider referred the student for additional cardiac screening or treatment.

As with other student health assessments under existing law, the bill requires schools to (1) provide the assessment for free if the student is eligible for free or reduced price meals and (2) record the assessment results in the student's health record.

The bill extends to these athletic health assessments certain other provisions that apply to student health assessments under existing law, including those shielding the records from public inspection and requiring a religious exemption (CGS §§ 10-208 & -209).

The bill also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2026

### *Annual Athletics Health Assessment*

Under the bill, the required athletic health assessment for high school student athletes must be done by a qualified health care provider, such as a physician, advanced practice registered nurse, or physician assistant. It must include a physical exam that screens for serious cardiac conditions that could lead to sudden death, with the screening done in line with guidelines set by the American Heart Association, the American College of Cardiology, or another organization focused on pediatric cardiovascular care.

The assessment form, to be supplied by the state Board of Education, must include:

1. a check box for the provider to indicate any patient or family history of serious cardiac symptoms, such as chest pain with exertion or unexplained syncope (fainting), and family history of sudden cardiac death;

2. screening questions for the parent or guardian about family history with these issues, including those listed above or sudden cardiac arrest;

3. any additional screening questions for the provider to answer as he or she deems necessary and appropriate; and

4. a check box for the provider to indicate whether he or she referred the student for additional cardiac screening or treatment.

### *Background — Related Bill*

sSB 194 (File 494), favorably reported by the Public Health Committee, contains similar provisions on health assessments for student athletes.

## § 18 — MENOPAUSE PROVIDER TOOLKIT

*Requires UConn's Health Disparities Institute to (1) develop a menopause toolkit for specified providers who diagnose or treat people with symptoms of menopause, perimenopause, and post-menopause; (2) distribute the toolkit to providers by June 1, 2028; and (3) distribute a revised toolkit by January 1, 2029, based on provider feedback*

The bill requires UConn Health Center's Health Disparities Institute, within available appropriations, to develop a menopause toolkit that provides practical, evidence-based, and culturally appropriate guidance on best practices for screening, identifying, clinically assessing, diagnosing, and treating symptoms of perimenopause, menopause, and post-menopause. Under the bill, the toolkit is for Connecticut health care providers who diagnose or treat people with symptoms of these conditions, as the institute determines, including those in the fields of obstetrics, gynecology, family medicine, internal medicine, emergency medicine, psychiatry, mental health, social work, dentistry, dental

hygiene, and community health.

The institute must develop the toolkit in consultation with DPH, people who have experienced symptoms of these conditions, and providers who treat them.

The guidance may include:

1. a comprehensive description of the symptoms of perimenopause, menopause, and post-menopause;
2. evidence-based guidelines for identifying and treating these symptoms, including hormone replacement therapy and testosterone therapy;
3. available insurance coverage for the therapies; and
4. short education models on the guidance that qualifies as continuing education for these providers.

Under the bill, the Health Disparities Institute must distribute the toolkit to providers by June 1, 2028. The institute must then evaluate any provider feedback it receives on the toolkit's effectiveness, revise the toolkit to address this feedback, and distribute any revised toolkit to providers by January 1, 2029.

### *Background — Related Bill*

sSB 5389 (File 114), favorably reported by the Public Health and Appropriations committees, requires DPH to develop and distribute to providers a menopause toolkit.

## §§ 19-22 — SCHOOL SAFETY PLANS

*Sets requirements for health care providers to share certain minors' safety plans with schools*

The bill regulates the review and sharing of certain minors' "safety plans" (written documents health care providers and patients create collaboratively, outlining coping strategies, activities, and support networks the patient can use to prevent or manage a potential mental health crisis).

Starting April 1, 2027, the bill requires each health care provider that prepares a safety plan for a minor patient who received at least 12 consecutive days of inpatient behavioral health care treatment to (1) review it with the minor, if medically appropriate, and (2) ask whether the minor or the minor's parent or legally authorized representative consents to sharing the safety plan with the minor's school. If this consent is given, the provider must (1) get written consent from the minor's parent or legally authorized representative (or the minor if they are at least age 16) and (2) send the plan to the minor's school or school district using a secure messaging system or in a way that complies with the federal Health Insurance Portability and Accountability Act (HIPAA).

Relatedly, the bill also requires:

1. school districts and schools to sign up for an organizational account on a secure messaging system and give at least one designated employee (such as a school nurse, social worker, or psychologist) access to the account;

2. local and regional education boards to give the State Department of Education (SDE) commissioner each school's and school district's secure messaging system address to make available to health care providers; and

3. local and regional education boards to give new designated employees SDE-developed guidance on how to use the secure messaging system.

Additionally, the bill makes it a goal of the Statewide Health Information Exchange ("Connie") to give, within available appropriations, schools and school districts a secure messaging system organizational account that designated employees may access to receive these safety plans.

EFFECTIVE DATE: Upon passage, except that the provision on guidance for new designated employees takes effect July 1, 2027.

### *Provider Requirements*

The bill specifies that its provisions do not create a standard of medical care for minor patients or require a health care provider to do the following:

1. create a safety plan;

2. release information to a minor patient's parent or legally authorized representative if state or federal law allows the minor to withhold the information (for example, for a pregnancy, abortion, contraception, HIV, mental health treatment, or any other area of care that the provider promised to keep confidential); or

3. transmit a safety plan or provide any other information to someone in violation of HIPAA.

### *Secure Messaging Systems*

The bill requires local and regional education boards, by January 1, 2027, to ensure that each school district or school, as determined by the board, (1) signs up for an organizational account on a "secure messaging system" (for example, one that complies with the federal Office of the National Coordinator for Health Information Technology's Direct Project specifications, see *Background — Direct Project Standards*) and (2) gives at least one designated employee (see below) access to the organizational account to access the safety plans.

Correspondingly, the bill makes it a goal of Connie to give, within available appropriations, (1) a secure messaging system organizational account to each board-determined school district and school to receive these safety plans and (2) designated employees access to the accounts (at no cost to schools, school districts, or their designated employees).

### *Designated Employees*

Under the bill, a "designated employee" is a school nurse or nurse practitioner, school nurse supervisor, school counselor, school social worker, or school psychologist who the local or regional education board designates to access the safety plans.

The bill requires at least one designated employee to be a school nurse supervisor. Designated employees must keep the safety plans in a confidential file separate from any cumulative academic or health record, so long as safety plan information may be used for appropriate interventions under a minor's individualized education program (IEP) or 504 plan (see *Background — IEP and 504 Plans*).

### *SDE List of Secure Messaging System Addresses*

The bill requires local and regional education boards to give the SDE commissioner each school district's and school's secure messaging system address by April 1, 2027. After this date, the education boards must also give the commissioner any address changes within 30 days after receiving them.

The bill requires the SDE commissioner to create and maintain a list of these secure messaging system addresses and make it available to the state's health care providers so they can send the safety plans.

### *Guidance for New Designated Employees*

Starting with the 2027-2028 school year, the bill requires each local and regional education board to provide guidance about the safety plans to new designated employees. More specifically, SDE must develop guidance and related training materials for the school boards to use that include instruction on using a secure messaging system to access safety plans sent by health care providers under the bill.

### *Background — Direct Project Standards*

The Direct Project is part of the Nationwide Health Information Network and specifies technical standards and services for health care providers to securely send authenticated, encrypted health information directly to trusted recipients online.

### *Background — IEP and 504 Plans*

An IEP is a written statement detailing a student's academic achievement level, goals for future achievement, and specialized educational services needed to reach the goals. Federal law requires school boards to develop IEPs for students eligible to receive special education and related services (Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq. (2024)). Section 504 of the federal Rehabilitation Act of 1973 protects students with mental or physical disabilities from discrimination in public schools (29 U.S.C. § 794 (2024)). Students who receive school accommodations under this law have them memorialized in a written plan, commonly known as a "504 plan."

### *Background — Related Bill*

sSB 5168 (File 682), favorably reported by the Education Committee, contains generally similar provisions regulating the review and sharing of certain minors' safety plans.

## §§ 23, 24 & 27 — NURSE'S AIDES

*Starting in October 2027, expands DPH's nurse's aide registry to include nurse's aides working at any DPH-licensed health care institution, rather than just nursing homes as under current law, and makes related changes to expand DPH's authority to take disciplinary action against nurse's aides who commit specified misconduct*

The bill expands DPH's nurse's aide registry to include nurse's aides working (as direct employees or under a contract) with any DPH-licensed health care institution, rather than just nursing homes as under current law. Under existing law, a nurse's aide must meet specified training and exam requirements to be registered.

The bill correspondingly expands DPH's authority to receive and investigate complaints and take disciplinary actions against nurse's aides to include those who work at any DPH-licensed institution. Under current law, the grounds for complaints against nurse's aides (just in nursing homes) include, among other things, resident abuse or neglect. The bill specifies that this applies to "abuse" or "neglect," as defined in specified federal regulations for long-term care facilities (42 C.F.R. § 483.5), of a health care institution resident, patient, or client. The bill also expands the grounds for complaints to include illegal, incompetent, or

negligent conduct in providing nursing or related services.

The bill authorizes DPH to issue a summary suspension of a nurse's aide's ability to practice before the final decision on a complaint or during the appeals process. This authority applies only if DPH finds that a nurse's aide represents a clear and immediate danger if allowed to continue to practice.

The bill also allows DPH, in line with existing procedures, to take disciplinary action against a nurse's aide after it investigates a complaint. By law, disciplinary actions available to DPH include, among other things, (1) revoking or suspending a credential; (2) censuring the violator; (3) issuing a letter of reprimand; (4) placing the violator on probationary status; or (5) imposing a civil penalty of up to $25,000 (CGS § 19a-17).

Under existing law, DPH can also render a finding against someone who is or has provided nurse's aide services and enter the finding in the registry, regardless of whether the aide is on the registry.

The bill also makes minor and conforming changes.

EFFECTIVE DATE: October 1, 2027

### *Background — Related Bill*

sSB 93, §§ 1, 2 & 5 (File 44), favorably reported by the Public Health Committee, contains substantially similar provisions on nurse's aides.

## §§ 25 & 26 — RURAL HEALTH TRANSFORMATION PROGRAM

*Allows DPH to take disciplinary action against a practitioner for failing to fulfill any material obligation resulting from the receipt of funding from DPH under the federally-funded Rural Health Transformation program; exempts program funding to the tribes from the general requirement that they first adopt an Employment Rights Code before the state can provide funds that assist a tribe engaged in a commercial enterprise*

The bill allows DPH, or its licensing boards or commissions, to take disciplinary action (see above) against a practitioner who fails to fulfill any material obligation resulting from receiving DPH funding under the Rural Health Transformation (RHT) program.

Generally, under existing law, before the state can give funds to help

the Mashantucket Pequot or Mohegan tribe when engaged in a commercial enterprise, the tribe must first adopt an Employment Rights Code with specified components. The bill exempts funding to tribes under the RHT program from this requirement.

Under the RHT program, created under 2025 federal legislation (P.L. 119-21, § 71401), the Centers for Medicare and Medicaid Services is giving all states grants to implement measures intended to expand rural health care access and quality. Connecticut is receiving a first-year grant of $154 million under the program. The Department of Social Services will serve as the lead agency under the grant funding, collaborating with several other agencies (including DPH) to implement projects across four initiatives: population health outcomes, workforce, data and technology, and care transformation and stability.

EFFECTIVE DATE: October 1, 2026, except the tribal-related provision takes effect upon passage.

### *Background — Related Bill*

sSB 93, §§ 3 & 4 (File 44), favorably reported by the Public Health Committee, contains similar provisions related to the RHT program.

## §§ 28-30 — EMS LICENSURE INTERSTATE COMPACT AND BACKGROUND CHECKS

*Enters Connecticut into the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact, no earlier than one year after a neighboring state enters it; correspondingly requires DPH to institute a criminal background check requirement for EMS personnel (starting one year after a neighboring state enters the compact); requires DPH to report on the compact's implementation within five years after the state enters it*

The bill enters Connecticut into the Recognition of Emergency Medical Services (EMS) Personnel Licensure Interstate Compact (EMS compact), but no earlier than one year after Massachusetts, New York, or Rhode Island enters it. (There are currently 25 member states to the compact; our neighboring states have not yet joined.)

The compact creates a process authorizing EMS personnel who are licensed in one member state to practice across state boundaries without requiring licensure in each state. Member states must grant the privilege to practice to EMS personnel who hold a valid, unencumbered license

(or other authorization) in another member state and who otherwise meet the compact's eligibility requirements. Generally, by joining the compact, Connecticut retains broad authority to license and regulate EMS personnel, but must grant qualifying EMS providers a privilege to practice in Connecticut. The compact applies to emergency medical technicians (EMTs), advanced EMTs (AEMTs), paramedics, or other EMS providers at a level between EMT and paramedic.

The compact is administered by the Interstate Commission for EMS Personnel Practice, which Connecticut joins under the bill once it enters the compact.

Among various other provisions, the compact:

1. sets eligibility criteria for states to join the compact and for EMS personnel to practice under it;
2. addresses several matters related to disciplinary actions for EMS personnel practicing under the compact, such as information sharing among member states and removal of the privilege to practice;
3. allows the commission to levy an annual assessment on member states or impose fees on other parties to cover its operational costs;
4. only allows amendments to the compact to take effect if all member states adopt them into law; and
5. has a process for states to withdraw from the compact.

A broad overview of the compact appears below.

Under the bill, corresponding to a compact requirement, the DPH commissioner must require anyone applying for EMS professional licensure or certification to submit to a state and national fingerprint-based criminal history records check. This applies starting one year after Massachusetts, New York, or Rhode Island enacts the EMS compact (when Connecticut can enter the compact under the bill).

Additionally, within five years after the compact is implemented in the state, the bill requires the DPH commissioner, in consultation with the Office of Policy and Management secretary, to report on its implementation to the Public Health Committee. The report must (1) assess the compact's impact on the state's EMS workforce and patient access to medical care and (2) include recommendations to further support EMS workforce development.

### *Compact Overview*

The compact creates a process authorizing EMS personnel to work in multiple states if they are licensed in one member state. A "license" is a state's authorization for someone to practice as an EMT, AEMT, paramedic, or level between EMT or paramedic. (In Connecticut, paramedics are licensed, while EMTs and AEMTs are certified, but all of these would constitute a "license" under the compact's definition.)

Under the compact, a "state" is a U.S. state, commonwealth, district, or territory. A "member state" is a state that has enacted the compact. A "home state" is the member state where someone is licensed to practice emergency medical services. A "remote state" is a member state where someone is not licensed.

"Privilege to practice" is someone's authorization to deliver emergency medical services in remote states as authorized under the compact.

### *Home State Licensure (§ 28(3))*

Under the compact, any member state in which someone holds a current license is a home state for the compact's purposes. A home state license authorizes someone to practice in a remote state under the privilege to practice only if the home state:

1. requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial EMT and paramedic licenses;

2. has a mechanism to receive and investigate complaints about individuals;

3. notifies the commission about any adverse action (such as disciplinary action against a license or a criminal conviction) or significant investigatory information (such as information that the individual represents an immediate threat to public health and safety) about an individual;

4. requires a criminal background check for initial licensure applicants, including fingerprints or other biometric-based information that meets FBI requirements (except for federal employees with a suitability determination under federal regulations); and

5. complies with the commission's rules.

A member state may require someone to get licensed in order to practice in that state under circumstances not authorized by the compact's privilege to practice.

### *Compact Privilege to Practice (§ 28(4))*

The compact requires member states to recognize the privilege to practice of someone licensed in another member state that complies with the above requirements. To exercise the privilege to practice under the compact, an individual must:

1. be at least age 18;

2. have a current unrestricted license (see above) in a member state as an EMT, AEMT, paramedic, or level between EMT and paramedic; and

3. practice under the supervision of a medical director (a physician licensed in a member state who is accountable for EMS personnel's care delivery).

Under the compact, someone providing patient care in a remote state under the privilege to practice must function within the home state's scope of practice unless and until it is modified by an appropriate authority in the remote state. Otherwise, someone practicing in a remote

state is subject to the remote state’s authority and rules.

### *Conditions of Practice in a Remote State (§ 28(5))*

Under the compact, an individual may practice in a remote state under a privilege to practice only in performing their EMS duties as assigned by an appropriate authority, and when the individual:

1. originates a patient transport in a home state and transports the patient to a remote state,

2. originates in the home state and enters a remote state to pick up a patient and provide care and transport to the home state,

3. enters a remote state to provide patient care or transport within that state,

4. enters a remote state to pick up a patient and provide care and transport to a third member state, or

5. complies with other conditions as determined by the commission’s rules.

### *Relationship to Emergency Management Assistance Compact (§ 28(6))*

Under the compact, if a member state’s governor declares a state of emergency or disaster that activates the Emergency Management Assistance Compact (EMAC), the EMAC compact prevails over any conflicting provisions of this compact as to anyone practicing in a remote state under the governor’s declaration. (All states are part of EMAC, under which states may provide personnel, equipment, and other supplies to assist other states in governor-declared emergencies.)

### *Veterans, Service Members Separating From Active-Duty Military, and Their Spouses (§ 28(7))*

Under the compact, member states must consider someone as satisfying the minimum training and examination requirements for a given EMS license if the person (1) is a veteran, active military service member, member of the National Guard and Reserve separating from an active-duty tour, or the spouse of such a person and (2) holds an

unrestricted NREMT certification at or about the level of the license being sought. Member states must expedite the processing of their licensure applications. These individuals practicing under the compact remain subject to the compact's adverse action provisions (§ 28(8)).

### *Respective States' Authority and Adverse Actions (§ 28(4), (8) & (9))*

The compact addresses several matters related to states' authority to investigate and discipline EMS personnel practicing under its procedures. Broadly, the compact maintains the home state's authority to regulate the home state license, while authorizing remote states to regulate the compact privilege to practice in their states. For investigations and adverse actions, a home state's EMS authority must give the same priority to conduct reported from remote states as it would to conduct within the home state.

The following are examples of the regulatory structure under the compact:

1. a home state has exclusive authority to impose adverse action against a home state license, but a remote state may take adverse action against an individual's privilege to practice in that state or take other actions needed to protect its citizens;

2. if someone's (a) home state license is restricted or suspended or (b) privilege to practice in any remote state is restricted, suspended, or revoked, he or she cannot practice in any remote state until the license or privilege is restored;

3. member states must report adverse actions and compact privilege restrictions, suspensions, or revocations to the commission;

4. member states may allow someone to participate in an alternative program for substance abuse recovery rather than imposing an adverse action, but the person must not practice in any other member state during that time without its prior authorization;

5. member states' EMS authorities may issue subpoenas to compel someone's testimony or the production of evidence (to be enforced as applicable by a remote state's courts), with the issuing state covering certain costs; and

6. member states may issue cease and desist orders to restrict, suspend, or revoke someone's privilege to practice in the state.

### *Compact Commission (§ 28(10) & (12))*

The compact is administered by the Interstate Commission for EMS Personnel Practice, which consists of one voting delegate from each state. The delegate must be the responsible official of the state's EMS authority or the official's designee. The compact sets several powers, duties, and procedures for the commission. For example, the commission:

1. may make rules, binding on member states, to coordinate the compact's implementation and administration (a rule has no effect if a majority of the member states' legislatures reject it);

2. may levy and collect an annual assessment from each member state or impose fees on other parties to cover its operational costs; and

3. must have its receipts and disbursements audited yearly and the audit report included in the commission's annual report.

The compact addresses several other matters regarding the commission and its operations, such as setting conditions under which its members, officers, and employees are immune from civil liability.

### *Coordinated Database (§ 28(11))*

Member states must submit specified information (for example, on licensure and disciplinary actions) about individuals covered by the compact for inclusion in a database the compact creates. The database administrator must promptly notify all member states about any adverse action against, or significant investigatory information on, someone in a member state.

Member states that contribute information to the database may designate information that may not be shared publicly without the state's express permission. If a member state's law requires information to be expunged, it must be removed from the database.

### *Compact Oversight, Dispute Resolution, Enforcement, Member Withdrawal, and Related Matters (§ 28(13)-(15))*

Among other related provisions, the compact:

1. requires each member state's executive, legislative, and judicial branches to enforce the compact and take necessary steps to carry out its purposes;

2. requires the commission to take specified steps if a member state defaults on its obligations under the compact, and after all other means of securing compliance have been exhausted, allows a defaulting state to be terminated from the compact upon a majority vote of the member states;

3. requires the commission, upon a member state's request, to attempt to resolve a compact-related dispute among member states or between member and non-member states;

4. requires the commission to enforce the compact and rules and allows it to bring legal action against a member state in default upon a majority vote (the case may be brought in the U.S. District Court for the District of Columbia or the federal district where the commission's principal offices are located);

5. allows a member state to withdraw from the compact by repealing the enabling legislation, but withdrawal does not take effect until six months after the repealing statute's enactment;

6. allows member states to amend the compact, but no amendment takes effect until all member states enact it into law;

7. requires the compact to be liberally construed to carry out its purposes, and if the compact is held to violate a member state's constitution, it remains in effect in the remaining member states;

and

8. specifies that the compact does not supersede state law or rules on EMS agency licensure.

### *Background — Related Bill*

sSB 93, §§ 6 & 7 (File 44), favorably reported by the Public Health Committee, contains identical provisions on the state joining the EMS compact and background checks.

## § 31 — WELL WATER TESTING RESULTS

*Allows health authorities to disclose private residential or semipublic well testing results to eligible parties without getting the DPH commissioner's approval, and expands the allowable recipients to include certain nearby property owners*

The bill removes the requirement for the DPH commissioner's approval before health authorities can disclose private residential or semipublic well testing results to certain parties, and expands the allowable recipients of the test results.

More specifically, the law requires an environmental laboratory that conducts water quality testing for these wells to report the results to DPH and the local health authority. Current law allows DPH and the local health authority, with the DPH commissioner's approval, to disclose the test results or related investigation information to certain parties. The bill eliminates the requirement for the commissioner's approval, and expands the allowable parties to include the owner of (1) any other property that obtains water from the well or (2) any property next to the property (a) where the well is located or (b) that obtains water from the well.

Under existing law, DPH and the local health authority (currently, only with the commissioner's approval) may also disclose the test results or investigation information to the following:

1. the property owner,

2. a prospective buyer who has signed a purchase contract,

3. a state agency's agent, or

4. other people or entities when disclosure is needed for DPH or the local health authority to carry out their duties.

### *Background — Related Bill*

HB 5167 (File 24), favorably reported by the Public Health Committee, contains identical provisions on well water testing results.

## § 32 — STATE EXTREME WEATHER PROTOCOLS

*Requires (1) DESPP to develop guidance on extreme hot and cold weather protocols and improvements to public communication of these protocols and (2) DOH to develop ways to improve outreach to unhoused people during extreme weather events*

The bill requires the Department of Emergency Services and Public Protection (DESPP) Division of Emergency Management and Homeland Security to develop guidance, in consultation with the governor's office, the Office of Policy and Management, and municipal leaders, on the following:

1. extreme hot and cold weather protocols that may include weather factors (for example, temperatures and wind chill) that will prompt the state and municipalities to open cooling and warming centers statewide and

2. improvements to public communication when extreme hot and cold weather protocols are activated.

The division must do this by January 1, 2027, and in consultation with the (1) governor's office; (2) Office of Policy and Management; (3) municipal leaders; (4) departments of housing (DOH), mental health and addiction services (DMHAS), and social services (DSS) commissioners; (5) United Way of Connecticut's 2-1-1 Infoline program; and (6) Connecticut Coalition to End Homelessness.

Additionally by this date, the bill requires DOH, in consultation with DMHAS and DSS, to develop ways of improving outreach to unhoused individuals during extreme hot and cold weather events based on an evaluation conducted by DOH and those who provide services to these individuals.

### *Background — Related Bill*

SB 364 (File 54), favorably reported by the Public Health Committee, requires DESPP's Division of Emergency Management and Homeland Security to develop, among other things, standardized extreme hot and cold weather protocols that include weather factors that will prompt the state and municipalities to require cooling and warming centers to open statewide.

## §§ 33-36 — DENTISTS

*Under certain conditions, allows dentists to administer cosmetic injections on patients' faces; eliminates the requirement that dentists remain on-site when delegating to dental assistants the taking of dental x-rays; adds to the list of topics from which dentists must select for certain hours of continuing education*

The bill generally allows dentists, if they meet certain training and professional liability insurance requirements, to administer nonsurgical cosmetic injections, such as Botox or dermal fillers, on patients' faces to change or improve their physical appearance. Current law prohibits dentists from performing cosmetic procedures, other than those related to the mouth or jaw.

The bill eliminates the requirement that dentists must remain on-site when delegating to a dental assistant the taking of dental x-rays.

By law, dentists' continuing education (CE) must include, every two years, one contact hour in any three of certain topics set by the DPH commissioner in consultation with the state dental commission. Under the bill, starting with CE registration periods beginning on or after October 1, 2026, DPH, in consultation with the commission, must expand the list from 10 to 12 items and must add to it (1) providing dental care to people with intellectual or developmental disability and (2) identifying victims of human trafficking. By law, dentists generally must complete 25 contact hours of CE every two years, starting with their second license renewal.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2026, except the CE provisions take effect July 1, 2026.

### *Dentists Performing Cosmetic Procedures*

To qualify to administer cosmetic injections under the bill, a dentist must (1) have completed an in-person hands-on training in this topic, administered by a CE provider or program approved by DPH or accredited by a national professional accrediting body and (2) maintain professional liability insurance that covers cosmetic injections.

The bill does not authorize a dentist to administer injections into:

1. specified areas near the eyes (such as the tear trough) for periocular volumization or under-eye hollow correction, or

2. the forehead, glabella (between the eyebrows and above the nose), or eyebrows for improved cosmesis.

The bill does not prohibit a dentist from administering:

1. a neuromodulator to the lateral canthal region (outer corner of the eye where the upper and lower eyelids meet), including to treat lateral canthal rhytids (commonly called "crow's feet");

2. an injection to manage orofacial pain, temporomandibular disorders (disorders in the jaw joint or muscles), or other oromandibular conditions; or

3. dermal filler to specified areas near the cheekbone or midface region when the primary intended treatment site is the cheek or midface and the injection site is lower than the infraorbital rim.

The bill prohibits dentists from delegating the administration of cosmetic injections to dental hygienists, dental assistants, or other auxiliary personnel.

It allows the DPH commissioner to adopt implementing regulations, including on minimum training standards, approved training courses, and patient safety requirements.

### *Dental Assistants Taking X-Rays*

By law, dentists can delegate the taking of dental x-rays to dental

assistants who meet certain examination requirements. The bill eliminates the requirement that this happens only under the dentist's direction supervision, removing the need for the dentist to remain on-site while the assistant takes x-rays. Similar to current law, it requires the dentist to approve the assistant's taking of x-rays and assume responsibility for the assistant doing so.

### *Background — Related Bill*

sHB 5399 (File 115), favorably reported by the Public Health Committee, contains similar provisions on dentists.

## § 37 — REPEALERS

*Repeals the statutory cap on executive director salaries in state agencies' calculations of grants to private agencies that provide employment opportunities, day services, or residential facility services*

The bill repeals statutory provisions that cap at $125,000 (subject to cost-of-living increases), executive director salaries in DDS's, DMHAS's, DSS's, and other state agencies' calculations of grants to private agencies that provide employment opportunities, day services, or residential facility services.

## COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 29 Nay 3 (03/23/2026)

Appropriations Committee

Joint Favorable
Yea 44 Nay 9 (04/17/2026)