



House of Representatives

File No. 742

General Assembly

February Session, 2026

(Reprint of File No. 540)

Substitute House Bill No. 5514
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 29, 2026

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

Be it enacted by the Senate and House of Representatives in General
Assembly convened:

1 Section 1. Subsection (a) of section 19a-490 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective October*
3 *1, 2026*):

4 (a) "Institution" means a hospital, short-term hospital special hospice,
5 hospice inpatient facility, residential care home, nursing home facility,
6 home health care agency, home health aide agency, behavioral health
7 facility, assisted living services agency, substance abuse treatment
8 facility, outpatient surgical facility, outpatient clinic, clinical laboratory,
9 blood collection facility, source plasma donation center, birth center, an
10 infirmary operated by an educational institution for the care of students
11 enrolled in [, and] such institution, faculty and employees of [,] such
12 institution, and the dependent family members of such students, faculty
13 and employees, which family members are enrolled in such institution's

14 health plan; a facility engaged in providing services for the prevention,
15 diagnosis, treatment or care of human health conditions, including
16 facilities operated and maintained by any state agency; and a residential
17 facility for persons with intellectual disability licensed pursuant to
18 section 17a-227 and certified to participate in the Title XIX Medicaid
19 program as an intermediate care facility for individuals with intellectual
20 disability. "Institution" does not include any facility for the care and
21 treatment of persons with mental illness or substance use disorder
22 operated or maintained by any state agency, except Whiting Forensic
23 Hospital and the hospital and psychiatric residential treatment facility
24 units of the Albert J. Solnit Children's Center;

25 Sec. 2. (Effective July 1, 2026) (a) As used in this section:

26 (1) "Assisted living services" has the same meaning as provided in
27 section 19a-693 of the general statutes;

28 (2) "Assisted living services agency" has the same meaning as
29 provided in section 19a-693 of the general statutes;

30 (3) "Commissioner" means the Commissioner of Public Health, or the
31 commissioner's designee;

32 (4) "Department" means the Department of Public Health; and

33 (5) "Managed residential community" has the same meaning as
34 provided in section 19a-693 of the general statutes.

35 (b) The Commissioner of Public Health shall establish a working
36 group to advise the Department of Public Health regarding (1) managed
37 residential communities in the state where assisted living services
38 agencies provide assisted living services to the residents of such
39 communities, and (2) whether licensure of such communities by the
40 department would enable the department and such communities to
41 improve the health, safety and overall well-being of such residents. The
42 working group shall include, but need not be limited to, not less than
43 three representatives of different managed residential communities in

44 the state, not less than three representatives of different assisted living
45 services agencies in the state, not less than three residents who are
46 receiving assisted living services in a managed residential community
47 in the state, one each from a different managed residential community,
48 not less than three relatives of residents who are receiving such services
49 from a managed residential community, one each from a different
50 managed residential community, and a representative of an association
51 of aging services organizations in the state. Not later than January 1,
52 2027, the working group shall report to the commissioner regarding its
53 findings and recommendations.

54 (c) Not later than February 1, 2027, the Commissioner of Public
55 Health shall report, in accordance with the provisions of section 11-4a
56 of the general statutes, to the joint standing committee of the General
57 Assembly having cognizance of matters relating to public health on the
58 findings and recommendations of the working group and, for each
59 finding and recommendation, whether the Department of Public Health
60 is in agreement with such finding and recommendation.

61 Sec. 3. (NEW) (*Effective July 1, 2026*) Notwithstanding the provisions
62 of chapter 381 of the general statutes, a nonprofit organization that
63 delivers optical glasses produced by an optician licensed under said
64 chapter to the ultimate wearer of such glasses at no cost to such wearer
65 may deliver such glasses to an authorized representative of such wearer
66 if such wearer is unavailable to receive the glasses in person from such
67 organization.

68 Sec. 4. (NEW) (*Effective October 1, 2026*) Not later than January 1, 2027,
69 each health care provider shall notify each patient, in writing, at the time
70 of the initial intake of such patient (1) of the laws concerning the length
71 of time that the provider is required to maintain patient medical records,
72 and (2) of the manner in which the patient may request copies of the
73 patient's medical records from the provider.

74 Sec. 5. Subsection (a) of section 17b-338 of the general statutes is
75 repealed and the following is substituted in lieu thereof (*Effective from*

76 *passage*):

77 (a) There is established a Long-Term Care Advisory Council which
78 shall consist of the following: (1) The executive director of the
79 Commission on Women, Children, Seniors, Equity and Opportunity, or
80 the executive director's designee; (2) the State Nursing Home
81 Ombudsman, or the ombudsman's designee; (3) the president of the
82 Coalition of Presidents of Resident Councils, or the president's designee;
83 (4) the executive director of the Legal Assistance Resource Center of
84 Connecticut, or the executive director's designee; (5) the state president
85 of AARP, or the president's designee; (6) one representative of a
86 bargaining unit for health care employees, appointed by the president
87 of the bargaining unit; (7) the president of LeadingAge Connecticut and
88 Rhode Island, Inc., or the president's designee; (8) the president of the
89 Connecticut Association of Health Care Facilities, or the president's
90 designee; (9) the president of the Connecticut Association of Residential
91 Care Homes, or the president's designee; (10) the president of the
92 Connecticut Hospital Association or the president's designee; (11) the
93 executive director of the Connecticut Assisted Living Association or the
94 executive director's designee; (12) the executive director of the
95 Connecticut Association for Homecare or the executive director's
96 designee; (13) the president of Connecticut Community Care, Inc. or the
97 president's designee; (14) one member of the Connecticut Association of
98 Area Agencies on Aging appointed by the agency; (15) the president of
99 the Connecticut chapter of the Connecticut Alzheimer's Association;
100 (16) one member of the Connecticut Association of Adult Day Centers
101 appointed by the association; (17) the president of the Connecticut
102 Chapter of the American College of Health Care Administrators, or the
103 president's designee; (18) the president of the Connecticut Council for
104 Persons with Disabilities, or the president's designee; (19) the president
105 of the Connecticut Association of Community Action Agencies, or the
106 president's designee; (20) a personal care attendant appointed by the
107 speaker of the House of Representatives; (21) a person who, in a home
108 setting, cares for a person with a disability and is appointed by the
109 president pro tempore of the Senate; (22) three persons with a disability

110 appointed one each by the majority leader of the House of
111 Representatives, the majority leader of the Senate and the minority
112 leader of the House of Representatives; (23) a legislator who is a member
113 of the Long-Term Care Planning Committee; (24) one member who is a
114 nonunion home health aide appointed by the minority leader of the
115 Senate; and (25) the executive director of the nonprofit entity designated
116 by the Governor in accordance with section 46a-10b to serve as the
117 Connecticut protection and advocacy system or the executive director's
118 designee.

119 Sec. 6. Subsection (d) of section 19a-127l of the general statutes is
120 repealed and the following is substituted in lieu thereof (*Effective from*
121 *passage*):

122 (d) The advisory committee shall consist of (1) four members who
123 represent and shall be appointed by the Connecticut Hospital
124 Association, including three members who represent three separate
125 hospitals that are not affiliated of which one such hospital is an
126 academic medical center; (2) one member who represents and shall be
127 appointed by the Connecticut Nursing Association; (3) two members
128 who represent and shall be appointed by the Connecticut Medical
129 Society, including one member who is an active medical care provider;
130 (4) two members who represent and shall be appointed by the
131 Connecticut Business and Industry Association, including one member
132 who represents a large business and one member who represents a
133 small business; (5) one member who represents and shall be appointed
134 by the Home Health Care Association; (6) one member who represents
135 and shall be appointed by the Connecticut Association of Health Care
136 Facilities; (7) one member who represents and shall be appointed by
137 LeadingAge Connecticut and Rhode Island, Inc.; (8) two members who
138 represent and shall be appointed by the AFL-CIO; (9) one member who
139 represents consumers of health care services and who shall be
140 appointed by the Commissioner of Public Health; (10) one member who
141 represents a school of public health and who shall be appointed by the
142 Commissioner of Public Health; (11) the Commissioner of Public Health
143 or said commissioner's designee; (12) the Commissioner of Social

144 Services or said commissioner's designee; (13) the Secretary of the Office
145 of Policy and Management or said secretary's designee; (14) two
146 members who represent licensed health plans and shall be appointed by
147 the Connecticut Association of Health Care Plans; (15) one member who
148 represents and shall be appointed by the federally designated state peer
149 review organization; and (16) one member who represents and shall be
150 appointed by the Connecticut Pharmaceutical Association. The
151 chairperson of the advisory committee shall be the Commissioner of
152 Public Health or said commissioner's designee. The chairperson of the
153 committee, with a vote of the majority of the members present, may
154 appoint ex-officio nonvoting members in specialties not represented
155 among voting members. Vacancies shall be filled by the person who
156 makes the appointment under this subsection.

157 Sec. 7. Subsection (b) of section 19a-515 of the general statutes is
158 repealed and the following is substituted in lieu thereof (*Effective from*
159 *passage*):

160 (b) Each licensee shall complete a minimum of forty hours of
161 continuing education every two years, including, but not limited to,
162 training in (1) Alzheimer's disease and dementia symptoms and care,
163 and (2) infection prevention and control. Such two-year period shall
164 commence on the first date of renewal of the licensee's license after
165 January 1, 2004. The continuing education shall be in areas related to the
166 licensee's practice. Qualifying continuing education activities are
167 courses offered or approved by the Connecticut Association of
168 Healthcare Facilities, LeadingAge Connecticut and Rhode Island, Inc.,
169 the Connecticut Assisted Living Association, the Connecticut Alliance
170 for Subacute Care, Inc., the Connecticut Chapter of the American
171 College of Health Care Administrators, the Association For Long Term
172 Care Financial Managers, the Alzheimer's Association or any accredited
173 college or university, or programs presented or approved by the
174 National Continuing Education Review Service of the National
175 Association of Boards of Examiners of Long Term Care Administrators,
176 the Association for Professionals in Infection Control and Epidemiology
177 or by federal or state departments or agencies.

178 Sec. 8. Subsection (g) of section 22a-430 of the 2026 supplement to the
179 general statutes is repealed and the following is substituted in lieu
180 thereof (*Effective from passage*):

181 (g) (1) The commissioner shall, by regulation adopted prior to
182 October 1, 1977, establish and define categories of discharges that
183 constitute household and small commercial subsurface sewage disposal
184 systems for which the commissioner shall delegate to the Commissioner
185 of Public Health the authority to issue permits or approvals and to hold
186 public hearings in accordance with this section, on and after said date.
187 Not later than July 1, 2026, but only after the working group has
188 convened pursuant to section 49 of public act 25-97 and consideration of
189 the recommendations provided by such working group pursuant to said
190 section, the commissioner shall post a notice of intent to amend such
191 regulations on the eRegulations System to establish and define
192 categories of discharges that constitute small community sewerage
193 systems and household and small commercial subsurface sewage
194 disposal systems. The Commissioner of Public Health shall adopt
195 regulations, in accordance with the provisions of chapter 54, to establish
196 minimum requirements for small community sewerage systems and
197 household and small commercial subsurface sewage disposal systems
198 and procedures for the issuance of such permits or approvals by the
199 local director of health or an environmental health specialist registered
200 pursuant to chapter 395. The commissioner shall issue and update
201 technical standards applicable to the design, installation, engineering
202 and operation of on-site sewage disposal systems under the jurisdiction
203 of the Department of Public Health. Such technical standards shall not
204 be considered regulations of Connecticut state agencies, as defined in
205 section 4-166. The commissioner may implement policies and
206 procedures necessary to implement the provisions of this subsection
207 while in the process of adopting such policies and procedures as
208 regulations, provided notice of intent to adopt regulations is published
209 on the eRegulations System not later than twenty days after the date of
210 implementation of such policies and procedures. Policies and
211 procedures implemented pursuant to this subsection shall be valid until

212 the time final regulations are adopted in accordance with the provisions
213 of chapter 54. As used in this subsection, small community sewerage
214 systems and household and small commercial disposal systems shall
215 include those subsurface sewage disposal systems with a capacity of ten
216 thousand gallons per day or less. Notwithstanding any provision of the
217 general statutes (1) the regulations adopted by the commissioner
218 pursuant to this subsection that are in effect as of July 1, 2017, shall apply
219 to household and small commercial subsurface sewage disposal
220 systems with a capacity of seven thousand five hundred gallons per day
221 or less, and (2) the regulations adopted by the commissioner pursuant
222 to this subsection that are in effect on or after July 1, 2026, shall apply to
223 small community sewerage systems, household systems and small
224 commercial subsurface sewerage disposal systems with a capacity of ten
225 thousand gallons per day or less. Any permit denied by the
226 Commissioner of Public Health, or a director of health or registered
227 environmental health specialist shall be subject to hearing and appeal in
228 the manner provided in section 19a-229. Any permit granted by the
229 Commissioner of Public Health, or a director of health or registered
230 environmental health specialist on or after October 1, 1977, shall be
231 deemed equivalent to a permit issued under subsection (b) of this
232 section.

233 (2) As used in this subdivision, "nitrogen removal technology" means
234 a system designed to remove nitrogen for use in subsurface sewage
235 disposal systems delegated to the Commissioner of Public Health
236 pursuant to subdivision (1) of this subsection, except systems regulated
237 pursuant to section 19a-35a. Not later than July 1, 2028, the
238 Commissioners of Public Health and Energy and Environmental
239 Protection shall consult with stakeholders with expertise in nitrogen
240 removal to:

241 (A) Determine nitrogen credit equal to the nitrogen credit values for
242 nitrogen removal technologies approved by the Department of Energy
243 and Environmental Protection and published in the technical standards
244 established pursuant to subdivision (1) of this subsection prior to July 1,
245 2028;

246 (B) Determine nitrogen credit equal to the nitrogen credit values for
247 nitrogen removal technologies approved by the Department of Energy
248 and Environmental Protection that have not been published prior to July
249 1, 2028, in the technical standards established pursuant to subdivision
250 (1) of this subsection, for nitrogen removal technologies that meet the
251 definition of subsurface sewage disposal systems as established in
252 regulation pursuant to subdivision (1) of this subsection; and

253 (C) Establish procedures and standards for the review and approval
254 of new nitrogen removal technologies, which procedures and standards
255 shall be supported by independent third-party testing and climate-
256 relevant field data demonstrating the effectiveness of the technology in
257 removing nitrogen. The Commissioner of Public Health shall (i) adopt
258 regulations, in accordance with the provisions of chapter 54, to
259 implement the provisions of this subparagraph, and (ii) publish
260 specifications for nitrogen removal technologies approved in
261 accordance with such procedures and standards in the technical
262 standards established pursuant to subdivision (1) of this subsection.

263 Sec. 9. Section 20-200 of the general statutes is repealed and the
264 following is substituted in lieu thereof (*Effective October 1, 2026*):

265 (a) (1) Notwithstanding the provisions of section 20-198, the
266 Department of Public Health may issue a license by endorsement to any
267 veterinarian of good professional character who is currently licensed
268 and practicing in some other state or territory, having requirements for
269 admission determined by the department to be at least equal to the
270 requirements of this state, upon the payment of a fee of five hundred
271 sixty-five dollars to said department. Notwithstanding the provisions of
272 section 20-198, the department may, upon payment of a fee of five
273 hundred sixty-five dollars, issue a license without examination to a
274 currently practicing, competent veterinarian in another state or territory
275 who [(1)] (A) holds a current valid license in good professional standing
276 issued after examination by another state or territory that maintains
277 licensing standards which, except for examination, are commensurate
278 with this state's standards, and [(2)] (B) has worked continuously as a

279 licensed veterinarian in an academic or clinical setting in another state
280 or territory for a period of not less than five years immediately
281 preceding the application for licensure without examination. No license
282 shall be issued under this section to any applicant against whom
283 professional disciplinary action is pending or who is the subject of an
284 unresolved complaint. The department shall inform the board annually
285 of the number of applications it receives for licensure under this section.

286 [(b)] (2) The Department of Public Health may issue a temporary
287 permit under this subsection to an applicant for licensure without
288 examination upon receipt of a completed application form,
289 accompanied by the fee for licensure without examination, a copy of a
290 current license from another state of the United States, the District of
291 Columbia or a commonwealth or territory subject to the laws of the
292 United States, and a notarized affidavit attesting that the license is valid
293 and belongs to the person requesting notarization. Such temporary
294 permit shall be valid for a period not to exceed one hundred twenty
295 calendar days and shall not be renewable. The department shall not
296 issue a temporary permit under this section to any applicant against
297 whom professional disciplinary action is pending, or who is the subject
298 of an unresolved complaint.

299 (b) Notwithstanding the provisions of section 20-198, the Department
300 of Public Health may issue a temporary permit to an applicant who (1)
301 is a graduate from a school located outside of the United States, its
302 territories or Canada with a degree of doctor of veterinary medicine, or
303 its equivalent, from a program acceptable to the American Veterinary
304 Medical Association as required to receive certification by the
305 Educational Commission for Foreign Veterinary Graduates, and (2) is
306 working toward receiving certification from the Educational
307 Commission for Foreign Veterinary Graduates or Program for the
308 Assessment of Veterinary Education Equivalence. Such temporary
309 permit shall authorize the holder to practice veterinary medicine only
310 under the direct supervision of a veterinarian who has been licensed
311 under chapter 384 for not less than two years. Such temporary permit
312 shall be valid for a period not to exceed two years after the date of

313 issuance, except such temporary permit shall be renewable once for a
314 period of two years if the applicant fails to receive certification from the
315 Educational Commission for Foreign Veterinary Graduates or Program
316 for the Assessment of Veterinary Education Equivalence within the first
317 two-year period. No fee shall be required for the issuance or renewal of
318 a temporary permit under this section. As used in this subsection,
319 "direct supervision" means the licensed veterinarian is present in the
320 office where the temporary permit holder is performing such holder's
321 duties and immediately available to furnish assistance and direction to
322 such holder throughout the performance of such duties.

323 Sec. 10. (*Effective from passage*) (a) There is established a veterinary
324 telemedicine working group. The working group shall (1) evaluate the
325 feasibility of permitting the establishment of a veterinarian-client-
326 patient relationship through veterinary telemedicine in the state when
327 an animal is in need of medical care or treatment, and (2) if the working
328 group determines that permitting such establishment is feasible, make
329 recommendations regarding the parameters of such relationship. The
330 working group shall be within the Legislative Department.

331 (b) The working group shall consist of the following members:

332 (1) The chairpersons and ranking members of the joint standing
333 committee of the General Assembly having cognizance of matters
334 relating to public health, or their designees;

335 (2) One appointed by the Senate chairperson of the joint standing
336 committee of the General Assembly having cognizance of matters
337 relating to public health, who shall be a member of an association of
338 veterinarians in the state;

339 (3) One appointed by the House chairperson of the joint standing
340 committee of the General Assembly having cognizance of matters
341 relating to public health, who shall be a proponent of the establishment
342 of a veterinarian-client-patient relationship through veterinary
343 telemedicine when an animal is in need of medical care or treatment;

344 (4) One appointed by the Senate ranking member of the joint standing
345 committee of the General Assembly having cognizance of matters
346 relating to public health, who shall be a proponent of the establishment
347 of a veterinarian-client-patient relationship through veterinary
348 telemedicine when an animal is in need of medical care or treatment;
349 and

350 (5) One appointed by the House ranking member of the joint standing
351 committee of the General Assembly having cognizance of matters
352 relating to public health, who shall be a member of an association of
353 veterinarians in the state.

354 (c) The administrative staff of the joint standing committee of the
355 General Assembly having cognizance of matters relating to public
356 health shall serve as administrative staff of the working group.

357 (d) Not later than January 1, 2027, the working group shall report, in
358 accordance with the provisions of section 11-4a of the general statutes,
359 regarding its evaluation and recommendations to the joint standing
360 committee of the General Assembly having cognizance of matters
361 relating to public health.

362 Sec. 11. Section 19a-127k of the general statutes is amended by adding
363 subsection (j) as follows (*Effective October 1, 2026*):

364 (NEW) (j) When conducting a community health needs assessment,
365 each hospital shall, if warranted by data available to the hospital,
366 consider including the nutritional needs of community members with
367 diabetes and congestive heart failure and, to the extent permissible
368 under federal law, include such nutritional needs in the hospital's
369 community health needs assessment.

370 Sec. 12. (NEW) (*Effective October 1, 2026*) (a) As used in this section:

371 (1) "Bridging prescription" means a temporary, short-term
372 prescription issued to ensure continuity of medication while a patient
373 awaits specialized care;

374 (2) "Buprenorphine" means a synthetic opiate with partial agonist
375 actions approved by the federal Food and Drug Administration or any
376 successor agency for the treatment of opioid use disorder;

377 (3) "Community provider" means a health care provider permitted by
378 state and federal law to prescribe buprenorphine for the treatment of
379 opioid use disorder;

380 (4) "Last-dose letter" means a formal, sealed document provided by a
381 hospital to a patient that confirms the exact date, time and amount of
382 the last dose of methadone administered to the patient;

383 (5) "Methadone" means a long-acting synthetic opioid agonist
384 approved by the federal Food and Drug Administration or any
385 successor agency for the treatment of opioid use disorder;

386 (6) "Opioid antagonist" means naloxone hydrochloride or any other
387 similarly acting and equally safe drug approved by the federal Food and
388 Drug Administration or any successor agency for the treatment of a
389 drug overdose;

390 (7) "Opioid use disorder" has the same meaning as provided in the
391 most recent edition of the American Psychiatric Association's
392 Diagnostic and Statistical Manual of Mental Disorders; and

393 (8) "Opioid treatment program" means a certified opioid treatment
394 program, as described in 42 CFR 8, as amended from time to time, that
395 is permitted by state and federal law to administer methadone for the
396 treatment of opioid use disorder.

397 (b) On and after January 1, 2027, each hospital licensed pursuant to
398 chapter 368v of the general statutes (1) may, to the extent permitted
399 under federal law, (A) administer buprenorphine or methadone to each
400 patient presenting to the hospital's emergency department with
401 symptoms of opioid use disorder without requiring the admission of the
402 patient to the hospital for the sole purpose of such administration,
403 provided (i) the administration of buprenorphine or methadone is

404 clinically indicated, and (ii) the patient consents to such administration,
405 (B) offer the patient a prescription for or a supply of an opioid antagonist
406 at the time of such patient's discharge from the emergency department
407 and, if the patient accepts the offer, provide the patient with such
408 prescription or dispense an opioid antagonist to the patient, and (C)
409 refer the patient to one or more community providers or opioid
410 treatment programs that can provide continuity in the prescription of
411 buprenorphine or administration of methadone, as applicable, and (2)
412 may, if clinically indicated, dispense a supply of methadone to each
413 such patient in accordance with the provisions of section 21 CFR 1306.
414 If a hospital administers buprenorphine to a patient under this
415 subsection, the hospital shall provide the patient, to the extent permitted
416 by federal law, with a bridging prescription for buprenorphine for the
417 anticipated time period during which the patient will be awaiting
418 treatment from the community provider to which the hospital refers the
419 patient. If a hospital administers or dispenses methadone to a patient
420 under this subsection, the hospital shall provide the patient with a last-
421 dose letter to provide to the local opioid treatment program to which
422 the hospital refers the patient.

423 (c) Nothing in this section shall be construed to (1) require the
424 provision of any medication when clinically contraindicated, (2) limit
425 the exercise of professional judgment by a treating clinician, or (3)
426 preclude the use of any medication other than buprenorphine or
427 methadone for opioid use disorder when such medication is clinically
428 indicated and the patient consents to the administration of such
429 medication.

430 Sec. 13. (NEW) (*Effective from passage*) (a) There is established a
431 working group regarding endometriosis for the purpose of evaluating
432 and making recommendations regarding the diagnosis, treatment,
433 research, education and public awareness of endometriosis in the state.
434 The working group shall be within the Legislative Department. The
435 working group shall evaluate the following:

436 (1) The prevalence and impact of endometriosis on residents of the

437 state;

438 (2) Barriers to timely and accurate diagnosis of endometriosis;

439 (3) Access to evidence-based treatment for endometriosis, including,
440 but not limited to, medical, surgical and therapeutic interventions;

441 (4) Insurance coverage and reimbursement practices for the
442 treatment of endometriosis;

443 (5) The impact of endometriosis in the workplace, including, but not
444 limited to, leave, accommodations and employment protections;

445 (6) Gaps in public and provider education and training concerning
446 endometriosis; and

447 (7) Opportunities to improve endometriosis data collection, research
448 initiatives and patient outcomes.

449 (b) The working group shall consist of the following members, who
450 shall be appointed not later than thirty days after the effective date of
451 this section:

452 (1) Four appointed by the speaker of the House of Representatives,
453 (A) one of whom shall be a member of the House or Representatives, (B)
454 one of whom shall be a physician licensed pursuant to chapter 370 of the
455 general statutes with demonstrated experience in the diagnosis and
456 treatment of endometriosis, (C) one of whom shall be a representative
457 of a federally qualified health center, and (D) one of whom shall be an
458 individual residing in the state who has been diagnosed with
459 endometriosis;

460 (2) Four appointed by the president pro tempore of the Senate, (A)
461 one of whom shall be a member of the Senate, (B) one of whom shall be
462 a physician licensed pursuant to chapter 370 of the general statutes who
463 is a member of the American College of Obstetricians and
464 Gynecologists, (C) one of whom shall be a researcher affiliated with an
465 academic or research institution in the state with expertise in

466 endometriosis, and (D) one of whom shall be a patient advocate with
467 experience advocating on behalf of individuals with endometriosis;

468 (3) Four appointed by the minority leader of the House of
469 Representatives, (A) one of whom shall be a member of the House of
470 Representatives, (B) one of whom shall be a pediatric or an adolescent
471 medicine physician licensed pursuant to chapter 370 of the general
472 statutes and currently practicing in the state, (C) one of whom shall be
473 an individual in the state with expertise in racial and health equity or
474 who represents a community-based organization serving historically
475 underserved populations, and (D) one of whom shall be a representative
476 of an association of hospitals in the state or an administrator of a hospital
477 in the state;

478 (4) Four appointed by the minority leader of the Senate, (A) one of
479 whom shall be a member of the Senate, (B) one of whom shall be a
480 representative of a school-based health center in the state, (C) one of
481 whom shall be a representative of a therapeutic or pharmaceutical
482 manufacturer with experience in treatments related to endometriosis,
483 and (D) one of whom shall be an individual residing in the state who
484 has been diagnosed with endometriosis;

485 (5) The Commissioner of Public Health, or the commissioner's
486 designee;

487 (6) The Insurance Commissioner, or the commissioner's designee;
488 and

489 (7) The cochairpersons of the endometriosis data and biorepository
490 program established pursuant to section 10a-132f of the general statutes.

491 (c) Except for members of the General Assembly, members who
492 represent state agencies and the cochairpersons of the endometriosis
493 data and biorepository program, six of the members first appointed
494 shall serve for a term of two years, six of such members shall serve for a
495 term of three years and, thereafter, members shall serve for a term of
496 two years. The executive director of the Commission on Women,

497 Children, Seniors, Equity and Opportunity shall determine which of the
498 members first appointed shall serve for a term of two years and which
499 of such members shall serve for a term of three years. Any vacancy shall
500 be filled by the appointing authority not later than thirty calendar days
501 after the appointment becomes vacant. Any member previously
502 appointed to the working group may be reappointed. The members of
503 the working group shall receive no compensation for their services but
504 may be reimbursed for any necessary expenses incurred in the
505 performance of their duties.

506 (d) The administrative staff of the Commission on Women, Children,
507 Seniors, Equity and Opportunity shall serve as administrative staff of
508 the working group. The executive director of said commission shall
509 schedule the first meeting of the working group which shall be held not
510 later than sixty days after the effective date of this section. The working
511 group shall appoint a chairperson and vice-chairperson from among its
512 members at its first meeting. The working group shall meet not less than
513 quarterly and provide an opportunity for public comment at its
514 meetings.

515 (e) Not later than January 1, 2027, and annually thereafter, the
516 working group shall report to the Governor and, in accordance with the
517 provisions of section 11-4a of the general statutes, to the joint standing
518 committees of the General Assembly having cognizance of matters
519 relating to human services and public health regarding its evaluation
520 and recommendations, including, but not limited to, for legislation
521 necessary to implement any of such recommendations.

522 Sec. 14. (NEW) (*Effective July 1, 2026*) (a) There is established an
523 advisory council on chimeric antigen receptor T-cell therapy and other
524 gene therapies. The council shall advise and make recommendations to
525 the Department of Public Health and other state agencies, as
526 appropriate, regarding (1) the availability of chimeric antigen receptor
527 T-cell therapy and other gene therapies in the state for the treatment of
528 cancer, (2) safe, equitable and financially sustainable delivery of such
529 therapies, (3) advanced training for clinical providers of such therapies,

530 (4) long-term follow-up and vector safety for patients receiving such
531 therapies, (5) the development of referral and management protocols for
532 such therapies, (6) education for clinicians, patients and patients'
533 relatives and caregivers regarding such therapies and such protocols, (7)
534 advising patients and their relatives and caregivers regarding the cost
535 and availability of insurance coverage for such therapies, (8)
536 opportunities for coordinating with research collaborations,
537 government agencies, including, but not limited to, the Centers for
538 Medicare and Medicaid Services, accrediting bodies and national
539 registries regarding such therapies, (9) the development of centers of
540 excellence in the state for the delivery of such therapies, including, but
541 not limited to, requiring accreditation of such centers, (10) the
542 development of a state-wide referral network to ensure all eligible
543 patients are matched with a center of excellence in the state, (11) the
544 development of safety protocols to address complications experienced
545 by patients receiving such therapies and other safety concerns, (12)
546 methods of providing psychosocial support to patients receiving such
547 therapies and their relatives and caregivers, and (13) methods of
548 tracking patient outcomes with a focus on equity as it relates to
549 diagnosis, race, ethnicity, geography and income.

550 (b) The council may perform the following functions:

551 (1) Consult with experts on chimeric antigen receptor T-cell therapy
552 and other gene therapies for the treatment of cancer to develop policy
553 recommendations for improving patient access to such therapies in the
554 state;

555 (2) Hold public hearings and otherwise make inquiries of and solicit
556 comments from the general public to assist with a study or survey of
557 persons living with cancer who have received such therapies, such
558 persons' caregivers and health care providers and patient advocates;
559 and

560 (3) Research and make recommendations to the Department of Public
561 Health and other state agencies.

562 (c) The council shall consist of the following members:

563 (1) The Commissioner of Public Health, or the commissioner's
564 designee;

565 (2) The Insurance Commissioner, or the commissioner's designee,
566 who may be the representative of a health carrier;

567 (3) The Commissioner of Social Services, or the commissioner's
568 designee;

569 (4) The health information technology officer, designated in
570 accordance with section 19a-754a of the general statutes, or the officer's
571 designee;

572 (5) Four appointed by the Senate chairperson of the joint standing
573 committee of the General Assembly having cognizance of matters
574 relating to public health, one of whom shall be a hematologist or
575 oncologist providing services to adults, one of whom shall be a specialist
576 in emerging cellular and genetic therapy, one of whom shall be an
577 expert in pharmacology and one of whom shall be an advocate for
578 patients with a condition that is treated by gene therapy;

579 (6) Four appointed by the House chairperson of the joint standing
580 committee of the General Assembly having cognizance of matters
581 relating to public health, one of whom shall be a patient who has
582 received chimeric antigen receptor T-cell therapy, one of whom shall be
583 a representative of an association of hospitals in the state, one of whom
584 shall be a pediatric hematologist or oncologist and one of whom shall be
585 a community health equity advocate;

586 (7) Four appointed by the Senate ranking member of the joint
587 standing committee of the General Assembly having cognizance of
588 matters relating to public health, one of whom shall be a representative
589 of an internationally recognized accreditation body for institutions
590 providing cellular therapies, one of whom shall be a representative of
591 an association of health carriers in the state, one of whom shall be the

592 director of a cellular therapy program in the state and one of whom shall
593 be a representative of the life sciences or biotechnology industry; and

594 (8) Four appointed by the House ranking member of the joint
595 standing committee of the General Assembly having cognizance of
596 matters relating to public health, one of whom shall be a representative,
597 family member or caregiver of a person living with cancer who has
598 received gene therapy, one of whom shall be an advocate for cancer
599 patients in the state, one of whom shall be a social worker or patient
600 navigator and one of whom shall be a director of a transplant and
601 cellular therapy program in the state.

602 (d) All initial appointments to the council shall be made not later than
603 October 31, 2026. Except for members of the council who represent state
604 agencies, members shall serve for a term of three years and any vacancy
605 shall be filled by the appointing authority. The members shall receive
606 no compensation for their services but may be reimbursed for any
607 necessary expenses incurred in the performance of their duties. The
608 Commissioner of Public Health shall select an acting chairperson of the
609 council from its members for the purpose of organizing the first council
610 meeting. Such chairperson shall schedule and convene the first meeting,
611 which shall be held not later than November 30, 2026. The members of
612 the council shall appoint, by majority vote, a chairperson and vice-
613 chairperson during the first meeting of the council. Thereafter, the
614 council shall meet not less than quarterly in person or on a remote
615 platform, as determined by the chairperson.

616 (e) The council shall be within the Department of Public Health for
617 administrative purposes only.

618 (f) Not later than one year after the date of its first meeting, and
619 annually thereafter, the council shall report, in accordance with the
620 provisions of section 11-4a of the general statutes, to the joint standing
621 committees of the General Assembly having cognizance of matters
622 relating to public health and insurance regarding its findings and
623 recommendations, including, but not limited to, (1) the council's

624 activities, research findings and any recommendations for proposed
625 legislative changes, and (2) any potential sources of funding for the
626 council's activities, including, but not limited to, grants, donations,
627 sponsorships or in-kind donations.

628 (g) The council may (1) apply for and accept grants, gifts, bequests,
629 sponsorships and in-kind donations of funds from federal and interstate
630 agencies, private firms, individuals and foundations for the purpose of
631 carrying out its responsibilities, and (2) enter into any contracts or
632 agreements, in accordance with any established procedures, as may be
633 necessary for the distribution or use of any received funds, services or
634 property in accordance with any requirements to fulfill any conditions
635 of a grant, gift, bequest, sponsorship or in-kind donation.

636 Sec. 15. Section 10-206 of the general statutes, as amended by section
637 39 of public act 26-1, is repealed and the following is substituted in lieu
638 thereof (*Effective July 1, 2026*):

639 (a) Each local or regional board of education shall require each pupil
640 enrolled in the public schools to have health assessments pursuant to
641 the provisions of this section. Such assessments shall be conducted by
642 (1) a legally qualified practitioner of medicine, (2) an advanced practice
643 registered nurse or registered nurse, licensed pursuant to chapter 378,
644 (3) a physician assistant, licensed pursuant to chapter 370, (4) a school
645 medical advisor, or (5) a legally qualified practitioner of medicine, an
646 advanced practice registered nurse or a physician assistant stationed at
647 any military base, to ascertain whether such pupil is suffering from any
648 physical disability tending to prevent such pupil from receiving the full
649 benefit of school work and to ascertain whether such school work
650 should be modified in order to prevent injury to the pupil or to secure
651 for the pupil a suitable program of education. No health assessment
652 shall be made of any pupil enrolled in the public schools unless such
653 examination is made in the presence of the parent or guardian or in the
654 presence of another school employee. The parent or guardian of such
655 pupil shall receive prior written notice and shall have a reasonable
656 opportunity to be present at such assessment or to provide for such

657 assessment himself or herself. A local or regional board of education
658 may deny continued attendance in public school to any pupil who fails
659 to obtain the health assessments required under this section.

660 (b) Each local or regional board of education shall require each pupil
661 to have a health assessment prior to public school enrollment. The
662 assessment shall include: (1) A physical examination [which] that shall
663 include hematocrit or hemoglobin tests, height, weight, blood pressure,
664 a medical risk assessment for lead poisoning and, when indicated by
665 such assessment, a test of the pupil's blood lead level, and, beginning
666 with the 2003-2004 school year, a chronic disease assessment which shall
667 include, but not be limited to, asthma. The assessment form shall
668 include (A) a check box for the provider conducting the assessment, as
669 provided in subsection (a) of this section, to indicate an asthma
670 diagnosis, (B) screening questions relating to appropriate public health
671 concerns to be answered by the parent or guardian, and (C) screening
672 questions to be answered by such provider; (2) an updating of
673 immunizations as required under section 10-204a, provided a registered
674 nurse may only update said immunizations pursuant to a written order
675 by a physician or physician assistant, licensed pursuant to chapter 370,
676 or an advanced practice registered nurse, licensed pursuant to chapter
677 378; (3) vision, hearing, speech and gross dental screenings; and (4) such
678 other information, including health and developmental history, as the
679 physician feels is necessary and appropriate. The assessment shall also
680 include tests for tuberculosis, sickle cell anemia and Cooley's anemia
681 where the local or regional board of education determines after
682 consultation with the school medical advisor and the local health
683 department, or in the case of a regional board of education, each local
684 health department, that such tests are necessary, provided a registered
685 nurse may only perform said tests pursuant to the written order of a
686 physician or physician assistant, licensed pursuant to chapter 370, or an
687 advanced practice registered nurse, licensed pursuant to chapter 378.

688 (c) Each local or regional board of education shall require each pupil
689 enrolled in the public schools to have health assessments in either grade
690 six or grade seven and in either grade nine or grade ten. The assessment

691 shall include: (1) A physical examination [which] that shall include
692 hematocrit or hemoglobin tests, height, weight, blood pressure, and,
693 beginning with the 2003-2004 school year, a chronic disease assessment
694 which shall include, but not be limited to, asthma as defined by the
695 Commissioner of Public Health pursuant to subsection (c) of section 19a-
696 62a, as amended by this act. The assessment form shall include (A) a
697 check box for the provider conducting the assessment, as provided in
698 subsection (a) of this section, to indicate an asthma diagnosis, (B)
699 screening questions relating to appropriate public health concerns to be
700 answered by the parent or guardian, and (C) screening questions to be
701 answered by such provider; (2) an updating of immunizations as
702 required under section 10-204a, provided a registered nurse may only
703 update said immunizations pursuant to a written order of a physician
704 or physician assistant, licensed pursuant to chapter 370, or an advanced
705 practice registered nurse, licensed pursuant to chapter 378; (3) vision,
706 hearing, postural and gross dental screenings; and (4) such other
707 information including a health history as the physician feels is necessary
708 and appropriate. The assessment shall also include tests for tuberculosis
709 and sickle cell anemia or Cooley's anemia where the local or regional
710 board of education, in consultation with the school medical advisor and
711 the local health department, or in the case of a regional board of
712 education, each local health department, determines that said screening
713 or test is necessary, provided a registered nurse may only perform said
714 tests pursuant to the written order of a physician or physician assistant,
715 licensed pursuant to chapter 370, or an advanced practice registered
716 nurse, licensed pursuant to chapter 378.

717 (d) For the school year commencing July 1, 2027, and each school year
718 thereafter, each local or regional board of education shall require each
719 pupil enrolled in grades nine to twelve, inclusive, in the public schools
720 to have an athletics health assessment prior to being permitted to
721 participate in interscholastic athletics for each academic year. The
722 athletics assessment shall include a physical examination that shall
723 include screening for serious cardiac conditions that could lead to
724 sudden cardiac death, which screening shall be performed in

725 accordance with guidelines established by the American Heart
726 Association, the American College of Cardiology or another
727 organization focused on cardiovascular care in pediatric populations.
728 The athletics assessment form shall include (1) a check box for the
729 provider conducting the athletics assessment, as provided in subsection
730 (a) of this section, to indicate any patient or family history of symptoms
731 of such serious cardiac conditions, including, but not limited to, chest
732 pain with exertion or unexplained syncope, and any family history of
733 sudden cardiac death, (2) screening questions relating to a family
734 history of such serious cardiac issues to be answered by the parent or
735 guardian, including, but not limited to, chest pain with exertion,
736 unexplained syncope, sudden cardiac arrest or sudden cardiac death,
737 (3) any additional cardiac screening questions to be answered by such
738 provider, as deemed necessary and appropriate by such provider, and
739 (4) a check box for the provider conducting the athletics assessment to
740 indicate whether the provider referred the pupil for any additional
741 cardiac screening or treatment.

742 [(d)] (e) The results of each assessment done pursuant to this section
743 and the results of screenings done pursuant to section 10-214, as
744 amended by [this act] public act 26-1, shall be recorded on forms
745 supplied by the State Board of Education. Each school nurse may reject
746 such results submitted on forms other than the forms supplied by the
747 State Board of Education and require the resubmission of such results
748 on such forms supplied by the State Board of Education. An asthma
749 action plan shall be included with each assessment form that indicates
750 an asthma diagnosis pursuant to subsections (b) and (c) of this section.
751 Such information shall be included in the cumulative health record of
752 each pupil and shall be kept on file in the school such pupil attends. If a
753 pupil permanently leaves the jurisdiction of the board of education, the
754 pupil's original cumulative health record shall be sent to the chief
755 administrative officer of the school district to which such student
756 moves. The board of education transmitting such health record shall
757 retain a true copy. Each physician, advanced practice registered nurse,
758 registered nurse, or physician assistant performing health assessments

759 and screenings pursuant to this section and section 10-214, as amended
760 by [this act] public act 26-1, shall completely fill out and sign each form
761 and any recommendations concerning the pupil shall be in writing.

762 [(e)] (f) Appropriate school health personnel shall review the results
763 of each assessment and screening as recorded pursuant to subsection
764 [(d)] (e) of this section. When, in the judgment of such health personnel,
765 a pupil, as defined in section 10-206a, as amended by this act, is in need
766 of further testing or treatment, the superintendent of schools shall give
767 written notice to the parent or guardian of such pupil and shall make
768 reasonable efforts to assure that such further testing or treatment is
769 provided. Such reasonable efforts shall include a determination of
770 whether or not the parent or guardian has obtained the necessary testing
771 or treatment for the pupil, and, if not, advising the parent or guardian
772 on how such testing or treatment may be obtained. The results of such
773 further testing or treatment shall be recorded pursuant to subsection
774 [(d)] (e) of this section, and shall be reviewed by school health personnel
775 pursuant to this subsection.

776 [(f)] (g) On and after October 1, 2017, each local or regional board of
777 education shall report to the local health department and the
778 Department of Public Health, on an triennial basis, the total number of
779 pupils per school and per school district having a diagnosis of asthma
780 (1) at the time of public school enrollment, (2) in grade six or seven, and
781 (3) in grade nine or ten. The report shall contain the asthma information
782 collected as required under subsections (b) and (c) of this section and
783 shall include pupil age, gender, race, ethnicity and school. Beginning on
784 October 1, 2021, and every three years thereafter, the Department of
785 Public Health shall review the asthma screening information reported
786 pursuant to this section and shall submit a report to the joint standing
787 committees of the General Assembly having cognizance of matters
788 relating to public health and education concerning asthma trends and
789 distributions among pupils enrolled in the public schools. The report
790 shall be submitted in accordance with the provisions of section 11-4a
791 and shall include, but not be limited to, (A) trends and findings based
792 on pupil age, gender, race, ethnicity, school and the education reference

793 group, as determined by the Department of Education for the town or
794 regional school district in which such school is located, and (B) activities
795 of the asthma screening monitoring system maintained under section
796 19a-62a, as amended by this act.

797 Sec. 16. Section 10-206a of the general statutes is repealed and the
798 following is substituted in lieu thereof (*Effective July 1, 2026*):

799 Each local or regional board of education shall provide for health
800 assessments pursuant to ~~[subsection (c)]~~ subsections (c) and (d) of
801 section 10-206, as amended by this act, without charge to all pupils
802 whose parents or guardians meet the eligibility requirements for free
803 and reduced price meals under the National School Lunch Program or
804 for free milk under the special milk program. To meet its obligations
805 pursuant to this section, a board of education may utilize existing
806 community resources and services.

807 Sec. 17. Section 19a-62a of the general statutes is repealed and the
808 following is substituted in lieu thereof (*Effective July 1, 2026*):

809 (a) The Commissioner of Public Health shall maintain a system of
810 monitoring asthma screening information reported to the Department
811 of Public Health pursuant to subsection ~~[(f)]~~ (g) of section 10-206, as
812 amended by this act.

813 (b) Not later than October 1, 2021, and triennially thereafter, the
814 Department of Public Health shall post on its Internet web site the
815 activities of the asthma screening monitoring system maintained under
816 subsection (a) of this section, including a report of the information
817 obtained by the department pursuant to subsection ~~[(f)]~~ (g) of section
818 10-206, as amended by this act.

819 Sec. 18. (NEW) (*Effective October 1, 2026*) (a) The University of
820 Connecticut Health Center's Health Disparities Institute, in consultation
821 with the Department of Public Health, persons who have experienced
822 symptoms of perimenopause, menopause and postmenopause, and
823 health care providers who treat persons with symptoms of

824 perimenopause, menopause and postmenopause, shall develop, within
825 available appropriations, a toolkit that provides practical, evidence-
826 based and culturally appropriate guidance to health care providers in
827 the state who are responsible for diagnosing or treating persons with
828 symptoms of menopause, perimenopause or postmenopause, as
829 determined by said institute, including, but not limited to, health care
830 providers in the fields of obstetrics, gynecology, internal medicine,
831 family medicine, emergency medicine, psychiatry, mental health, social
832 work, dentistry, dental hygiene and community health, regarding best
833 practices for screening, identification, clinical assessment, diagnosis and
834 treatment of symptoms of menopause, perimenopause and
835 postmenopause. Such guidance may include, but need not be limited to,
836 (1) a comprehensive description of the symptoms of menopause,
837 perimenopause and postmenopause, (2) evidence-based guidelines
838 regarding the identification and treatment of such symptoms, including,
839 but not limited to, the use of hormones, such as hormone replacement
840 therapy and testosterone therapy, (3) the availability of insurance
841 coverage for such therapies, and (4) short education modules regarding
842 such guidance that would qualify as continuing education for such
843 health care providers.

844 (b) Not later than June 1, 2028, The University of Connecticut Health
845 Center's Health Disparities Institute shall distribute the toolkit
846 developed pursuant to subsection (a) of this section to such health care
847 providers. Not later than January 1, 2029, the institute shall (1) evaluate
848 any feedback received from such health care providers regarding the
849 effectiveness of the toolkit, (2) revise the toolkit as necessary to address
850 such feedback, and (3) distribute a revised toolkit, if any, to such health
851 care providers.

852 Sec. 19. (NEW) (*Effective from passage*) (a) As used in this section:

853 (1) "Designated employee" means a school nurse or nurse practitioner
854 appointed pursuant to section 10-212 of the general statutes, school
855 nurse supervisor, school counselor, school social worker or school
856 psychologist who a local or regional school board of education

857 designates to access safety plans of minor patients transmitted by health
858 care providers to a school district or school's secure messaging system
859 account pursuant to the provisions of this section;

860 (2) "Health care provider" means any person, corporation, limited
861 liability company, facility or institution operated, owned or licensed by
862 this state to provide health care or professional medical services;

863 (3) "Legally authorized representative" means a minor patient's
864 parent, guardian appointed by the Probate Court or a personal
865 representative, as described in 45 CFR 164.502(g);

866 (4) "Safety plan" means a written document created collaboratively
867 between a health care provider and a patient outlining coping strategies,
868 activities and support networks the patient can access to prevent or
869 manage a potential mental health crisis;

870 (5) "School nurse supervisor" means a school nurse or nurse
871 practitioner appointed pursuant to section 10-212 of the general statutes
872 designated by the local or regional board of education as the supervisor,
873 or, if no designation has been made by the board, the lead or
874 coordinating school nurse or nurse practitioner; and

875 (6) "Secure messaging system" means a platform capable of sending
876 and receiving secure messages and may include a platform that
877 complies with the Direct Project specifications published by the federal
878 Office of the National Coordinator for Health Information Technology.

879 (b) On and after April 1, 2027, each health care provider that prepares
880 a safety plan for a minor patient who received inpatient behavioral
881 health care treatment for a period not less than twelve consecutive days
882 shall (1) review such safety plan with the minor patient if the health care
883 provider believes such a review is medically appropriate, and (2)
884 inquire as to whether the minor patient or minor patient's parent or
885 legally authorized representative consents to sharing such safety plan
886 with the minor patient's school. If the minor patient or minor patient's
887 parent or legally authorized representative consents to sharing such

888 safety plan with the minor patient's school, the health care provider
889 shall obtain written consent from (A) the minor patient's parent or
890 legally authorized representative, or (B) if the minor patient is sixteen
891 years of age or older, such minor patient, and transmit such safety plan
892 to the minor patient's school district or school (i) using a secure
893 messaging system, or (ii) in a form and manner that complies with the
894 Health Insurance Portability and Accountability Act of 1996, P.L. 104-
895 191, as amended from time to time, and 45 CFR 160.101 to 45 CFR
896 164.534, inclusive, as amended from time to time.

897 (c) Nothing in this section shall be construed to (1) create a standard
898 of medical care with respect to any minor patient, (2) require a health
899 care provider to create a safety plan, (3) require a health care provider
900 to release information to a parent or legally authorized representative if,
901 pursuant to state or federal law, a minor patient may withhold such
902 information from such minor patient's parent or legally authorized
903 representative, including, but not limited to, information regarding
904 pregnancy, abortion, contraceptives, human immunodeficiency virus or
905 other sexually transmitted disease testing or treatment, mental health
906 treatment or any other area of care that a health care provider has
907 promised a minor patient that the health care provider will keep
908 confidential, or (4) require a health care provider to transmit a safety
909 plan or provide any other information to any person in violation of the
910 provisions of the Health Insurance Portability and Accountability Act of
911 1996, P.L. 104-191, as amended from time to time.

912 Sec. 20. (NEW) (*Effective from passage*) (a) On or before January 1, 2027,
913 each local or regional board of education shall ensure that each school
914 district or school, as determined by the board, (1) signs up for an
915 organizational account on a secure messaging system, as defined in
916 section 19 of this act, and (2) provides access to one or more designated
917 employees, as defined in section 19 of this act, one of whom shall be a
918 school nurse supervisor, as defined in section 19 of this act, to such
919 organizational account for the purpose of accessing minor patient safety
920 plans, as defined in section 19 of this act, transmitted by health care
921 providers, pursuant to the provisions of section 19 of this act. A

922 designated employee shall retain minor patient safety plans in a
923 confidential file separate from any cumulative academic or health
924 record, provided information contained in a minor patient safety plan
925 may be used to provide appropriate interventions pursuant to an
926 individualized education program or a plan pursuant to Section 504 of
927 the Rehabilitation Act of 1973.

928 (b) On or before April 1, 2027, each local or regional board of
929 education shall submit each school district or school's secure messaging
930 system address to the Commissioner of Education in a form and manner
931 prescribed by the commissioner. On and after April 1, 2027, if a school
932 district or school's secure messaging system address changes, each local
933 or regional board of education shall, in a form and manner prescribed
934 by the commissioner, submit such new address to the commissioner as
935 soon as practicable but not later than thirty days after acquiring such
936 new address. The commissioner shall compile and maintain a list of each
937 school district or school's secure messaging system address and make
938 such list available to health care providers in the state for the purpose of
939 transmitting minor patient safety plans pursuant to the provisions of
940 section 19 of this act.

941 Sec. 21. (NEW) (*Effective July 1, 2027*) For the school year commencing
942 July 1, 2027, and each school year thereafter, each local and regional
943 board of education shall provide guidance regarding the requirements
944 of section 19 of this act for all new designated employees, as defined in
945 section 19 of this act. The Department of Education shall develop and
946 make available such guidance and training materials for use by each
947 local and regional board of education. Such materials shall include
948 instruction for using a secure messaging system for the purpose of
949 accessing minor patient safety plans, as defined in section 19 of this act,
950 transmitted by health care providers pursuant to the provisions of
951 section 19 of this act.

952 Sec. 22. Subsection (b) of section 17b-59d of the general statutes is
953 repealed and the following is substituted in lieu thereof (*Effective from*
954 *passage*):

955 (b) It shall be the goal of the State-wide Health Information Exchange
956 to: (1) Allow real-time, secure access to patient health information and
957 complete medical records across all health care provider settings; (2)
958 provide patients with secure electronic access to their health
959 information in accordance with 45 CFR 171; (3) allow voluntary
960 participation by patients to access their health information at no cost; (4)
961 support care coordination through real-time alerts and timely access to
962 clinical information; (5) reduce costs associated with preventable
963 readmissions, duplicative testing and medical errors; (6) promote the
964 highest level of interoperability; (7) meet all state and federal privacy
965 and security requirements; (8) support public health reporting, quality
966 improvement, academic research and health care delivery and payment
967 reform through data aggregation and analytics; (9) support population
968 health analytics; (10) be standards-based; [and] (11) provide for broad
969 local governance that (A) includes stakeholders, including, but not
970 limited to, representatives of the Department of Social Services,
971 hospitals, physicians, behavioral health care providers, long-term care
972 providers, health insurers, employers, patients and academic or medical
973 research institutions, and (B) is committed to the successful
974 development and implementation of the State-wide Health Information
975 Exchange; and (12) provide, within available appropriations, (A) a
976 secure messaging system organizational account to each school district
977 or school, as determined by each local and regional board of education,
978 for the purposes of receiving minor patient safety plans pursuant to the
979 provisions of section 19 of this act, and (B) access to such organizational
980 account for designated employees, as defined in section 19 of this act, at
981 no cost to such school district, school and designated employee.

982 Sec. 23. Section 20-102aa of the general statutes is repealed and the
983 following is substituted in lieu thereof (*Effective October 1, 2027*):

984 As used in subsection (c) of section 19a-14 and sections 20-102aa to
985 20-102ff, inclusive, as amended by this act:

986 (1) "Abuse" means any act of abuse, as defined in 42 CFR 483.5, as
987 amended from time to time, committed towards a client, resident or

988 patient;

989 [(1)] (2) "Commissioner" means the Commissioner of Public Health;

990 (3) "Neglect" means any act of neglect, as defined in 42 CFR 483.5, as
991 amended from time to time, committed towards a client, resident or
992 patient;

993 [(2) "nurse's aide"] (4) "Nurse's aide" means [an individual providing]
994 a registered nurse's aide who provides nursing or nursing-related
995 services [to residents in a chronic and convalescent nursing home or rest
996 home with nursing supervision] pursuant to such nurse's aide's
997 employment or contract with an institution, as defined in section 19a-
998 490, as amended by this act, but does not include an individual who is a
999 health professional otherwise licensed or certified by the Department of
1000 Public Health, or who volunteers to provide such services without
1001 monetary compensation;

1002 [(3) "registration"] (5) "Registration" means a document issued by the
1003 Department of Public Health to a nurse's aide which certifies that such
1004 aide has satisfied the training and competency evaluation requirements
1005 prescribed by the commissioner; [and has been found qualified for
1006 employment in a chronic and convalescent nursing home or rest home
1007 with nursing supervision;] and

1008 [(4) "registered nurse's aide"] (6) "Registered nurse's aide" means an
1009 individual who has been issued a registration as defined in this section.

1010 Sec. 24. Subsection (a) of section 20-102cc of the general statutes is
1011 repealed and the following is substituted in lieu thereof (*Effective October*
1012 *1, 2027*):

1013 (a) The Department of Public Health shall receive, investigate and
1014 prosecute complaints against individuals who are providing or have
1015 provided services as a nurse's aide in [a chronic and convalescent
1016 nursing home or rest home with nursing supervision] an institution, as
1017 defined in section 19a-490, as amended by this act. The grounds for

1018 complaint shall include [resident abuse, resident neglect,] (1) illegal,
1019 incompetent or negligent conduct in the provision of nursing or
1020 nursing-related services, (2) abuse of a resident, patient or client, (3)
1021 neglect of a resident, patient or client, (4) misappropriation of resident,
1022 patient or client property, and (5) fraud or deceit in obtaining or
1023 attempting to obtain a registration as a nurse's aide. A nurse's aide shall
1024 be given written notice by certified mail by the commissioner of any
1025 complaint against him or her. The department may summarily suspend
1026 a nurse's aide's ability to practice in advance of a final adjudication on a
1027 complaint or during the appeals process in accordance with subsection
1028 (c) of section 19a-17. A nurse's aide who wishes to appeal a complaint
1029 against him or her shall, not later than thirty days after the date of the
1030 mailing, file with the department a request in writing for a hearing to
1031 contest the complaint. The commissioner shall render a finding on such
1032 complaint, and, if a hearing is requested, it shall be conducted pursuant
1033 to chapter 54. The commissioner shall have the authority to take any
1034 action against a nurse's aide set forth in section 19a-17, as amended by
1035 this act, and to render a finding and enter such finding on the registry
1036 against an individual who is providing or has provided services as a
1037 nurse's aide, [in a chronic and convalescent nursing home or rest home
1038 with nursing supervision,] without regard to whether such individual
1039 is on the registry or has obtained registration as a nurse's aide from the
1040 department.

1041 Sec. 25. Section 19a-17 of the 2026 supplement to the general statutes
1042 is amended by adding subsection (i) as follows (*Effective October 1, 2026*):

1043 (NEW) (i) Such board or commission or the department may take any
1044 of the actions permitted under this section against a practitioner for
1045 failure to fulfill any material obligation resulting from the receipt of
1046 funds provided by the department pursuant to the Rural Health
1047 Transformation Program established pursuant to 42 USC 1397ee(h).

1048 Sec. 26. Section 31-57e of the 2026 supplement to the general statutes
1049 is amended by adding subsection (f) as follows (*Effective from passage*):

1050 (NEW) (f) The provisions of this section shall not apply to the
1051 provision of funds to a tribe pursuant to the Rural Health
1052 Transformation Program established pursuant to 42 USC 1397ee(h).

1053 Sec. 27. Subsection (a) of section 20-102ee of the general statutes is
1054 repealed and the following is substituted in lieu thereof (*Effective October*
1055 *1, 2027*):

1056 (a) The Commissioner of Public Health shall adopt regulations, in
1057 accordance with the provisions of chapter 54, concerning the regulation
1058 of nurse's aides. Such regulations shall require a training program for
1059 nurse's aides of not less than one hundred hours. Not less than seventy-
1060 five of such hours shall include, but not be limited to, basic nursing
1061 skills, personal care skills, care of cognitively impaired [residents]
1062 patients, recognition of mental health and social service needs, basic
1063 restorative services and [residents'] patients' rights. Not less than
1064 twenty-five of such hours shall include, but not be limited to, specialized
1065 training in understanding and responding to challenging behaviors
1066 related to physical, psychiatric, psychosocial and cognitive disorders.
1067 On and after January 1, 2022, not less than two of such hours shall
1068 include (1) screening for post-traumatic stress disorder, risk of suicide,
1069 depression and grief, and (2) suicide prevention training offered or
1070 approved by the American Nurses Association, Connecticut Hospital
1071 Association, Connecticut Nurses Association or Connecticut League for
1072 Nursing, a specialty nursing society or equivalent organization in
1073 another jurisdiction, a hospital or other health care institution, a
1074 regionally accredited academic institution, or a state or local health
1075 department. The requirement described in subdivision (2) of this section
1076 may be satisfied by the completion of the evidence-based youth suicide
1077 prevention training program administered pursuant to section 17a-52a.

1078 Sec. 28. (NEW) (*Effective October 1, 2026*) The Recognition of
1079 Emergency Medical Services Personnel Licensure Interstate Compact
1080 shall be enacted into law and entered into by the state of Connecticut
1081 with any and all states legally joining therein in accordance with its
1082 terms not earlier than one year after the date on which such compact is

1083 enacted in at least one of the states of Massachusetts, New York or
1084 Rhode Island. The compact is substantially as follows:

1085 RECOGNITION OF EMERGENCY MEDICAL SERVICES
1086 PERSONNEL LICENSURE INTERSTATE COMPACT

1087 SECTION 1. PURPOSE

1088 In order to protect the public through verification of competency and
1089 ensure accountability for patient care related activities, all states license
1090 emergency medical services (EMS) personnel, such as emergency
1091 medical technicians (EMTs), advanced EMTs and paramedics. This
1092 compact is intended to facilitate the day-to-day movement of EMS
1093 personnel across state boundaries in the performance of their EMS
1094 duties as assigned by an appropriate authority and authorize state EMS
1095 offices to afford immediate legal recognition to EMS personnel licensed
1096 in a member state.

1097 This compact recognizes that states have a vested interest in
1098 protecting the public's health and safety through their licensing and
1099 regulation of EMS personnel and that such state regulation shared
1100 among the member states will best protect public health and safety. This
1101 compact is designed to achieve the following purposes and objectives:

- 1102 (1) Increase public access to EMS personnel;
- 1103 (2) Enhance the states' ability to protect the public's health and safety,
1104 especially patient safety;
- 1105 (3) Encourage the cooperation of member states in the areas of EMS
1106 personnel licensure and regulation;
- 1107 (4) Support licensing of military members who are separating from
1108 an active-duty tour and their spouses;
- 1109 (5) Facilitate the exchange of information between member states
1110 regarding EMS personnel licensure, adverse action and significant
1111 investigatory information;

1112 (6) Promote compliance with the laws governing EMS personnel
1113 practice in each member state; and

1114 (7) Invest all member states with the authority to hold EMS personnel
1115 accountable through the mutual recognition of member state licenses.

1116 SECTION 2. DEFINITIONS

1117 As used in section 1, this section and sections 3 to 15, inclusive, of
1118 the compact:

1119 (1) "Advanced emergency medical technician" or "AEMT" means an
1120 individual licensed with cognitive knowledge and a scope of practice
1121 that corresponds to that level in the National EMS Education Standards
1122 and National EMS Scope of Practice Model.

1123 (2) "Adverse action" means any administrative, civil, equitable or
1124 criminal action permitted by a state's laws that may be imposed against
1125 licensed EMS personnel by a state EMS authority or state court,
1126 including, but not limited to, actions against an individual's license such
1127 as revocation, suspension, probation, consent agreement, monitoring or
1128 other limitation or encumbrance on the individual's practice, letters of
1129 reprimand or admonition, fines, criminal convictions and state court
1130 judgments enforcing adverse actions by the state EMS authority.

1131 (3) "Alternative program" means a voluntary, nondisciplinary
1132 substance abuse recovery program approved by a state EMS authority.

1133 (4) "Certification" means the successful verification of entry-level
1134 cognitive and psychomotor competency using a reliable, validated and
1135 legally defensible examination.

1136 (5) "Commission" means the national administrative body of which
1137 all states that have enacted the compact are members.

1138 (6) "Emergency medical technician" or "EMT" means an individual
1139 licensed with cognitive knowledge and a scope of practice that
1140 corresponds to that level in the National EMS Education Standards and

1141 National EMS Scope of Practice Model.

1142 (7) "Home state" means a member state where an individual is
1143 licensed to practice emergency medical services.

1144 (8) "License" means the authorization by a state for an individual to
1145 practice as an EMT, AEMT or paramedic, or a level between EMT and
1146 paramedic.

1147 (9) "Medical director" means a physician licensed in a member state
1148 who is accountable for the care delivered by EMS personnel.

1149 (10) "Member state" means a state that has enacted this compact.

1150 (11) "Privilege to practice" means an individual's authority to deliver
1151 emergency medical services in remote states as authorized under this
1152 compact.

1153 (12) "Paramedic" means an individual licensed with cognitive
1154 knowledge and a scope of practice that corresponds to that level in the
1155 National EMS Education Standards and National EMS Scope of Practice
1156 Model.

1157 (13) "Remote state" means a member state in which an individual is
1158 not licensed.

1159 (14) "Restricted" means the outcome of an adverse action that limits a
1160 license or the privilege to practice.

1161 (15) "Rule" means a written statement by the Interstate Commission
1162 promulgated pursuant to section 12 of this compact that (A) is of general
1163 applicability, (B) implements, interprets or prescribes a policy or
1164 provision of the compact, or (C) is an organizational, procedural or
1165 practice requirement of the Commission, and (D) has the force and effect
1166 of statutory law in a member state and includes the amendment, repeal
1167 or suspension of an existing rule.

1168 (16) "Scope of practice" means defined parameters of various duties

1169 or services that may be provided by an individual with specific
1170 credentials. Whether regulated by rule, statute or court decision, it tends
1171 to represent the limits of services an individual may perform.

1172 (17) "Significant investigatory information" means:

1173 (A) Investigative information that a state EMS authority, after a
1174 preliminary inquiry that includes notification and an opportunity to
1175 respond if required by state law, has reason to believe, if proved true,
1176 would result in the imposition of an adverse action on a license or
1177 privilege to practice; or

1178 (B) Investigative information that indicates that the individual
1179 represents an immediate threat to public health and safety regardless of
1180 whether the individual has been notified and had an opportunity to
1181 respond.

1182 (18) "State" means any state, commonwealth, district or territory of
1183 the United States.

1184 (19) "State EMS authority" means the board, office or other agency
1185 with the legislative mandate to license EMS personnel.

1186 SECTION 3. HOME STATE LICENSURE

1187 (a) Any member state in which an individual holds a current license
1188 shall be deemed a home state for purposes of this compact.

1189 (b) Any member state may require an individual to obtain and retain
1190 a license to be authorized to practice in the member state under
1191 circumstances not authorized by the privilege to practice under the
1192 terms of this compact.

1193 (c) A home state's license authorizes an individual to practice in a
1194 remote state under the privilege to practice only if the home state:

1195 (1) Currently requires the use of the National Registry of Emergency
1196 Medical Technicians (NREMT) examination as a condition of issuing

1197 initial licenses at the EMT and paramedic levels;

1198 (2) Has a mechanism in place for receiving and investigating
1199 complaints about individuals;

1200 (3) Notifies the Commission, in compliance with the terms herein, of
1201 any adverse action or significant investigatory information regarding an
1202 individual;

1203 (4) Not later than five years after activation of the compact, requires
1204 a criminal background check of all applicants for initial licensure,
1205 including the use of the results of fingerprint or other biometric data
1206 checks compliant with the requirements of the Federal Bureau of
1207 Investigation with the exception of federal employees who have
1208 suitability determination in accordance with US CFR 731.202 and
1209 submit documentation of such as promulgated in the rules of the
1210 Commission; and

1211 (5) Complies with the rules of the Commission.

1212 SECTION 4. COMPACT PRIVILEGE TO PRACTICE

1213 (a) Member states shall recognize the privilege to practice of an
1214 individual licensed in another member state that is in conformance with
1215 section 3 of this compact.

1216 (b) To exercise the privilege to practice under the terms and
1217 provisions of this compact, an individual shall:

1218 (1) Be at least eighteen years of age;

1219 (2) Possess a current unrestricted license in a member state as an
1220 EMT, AEMT, paramedic or state-recognized and licensed level with a
1221 scope of practice and authority between EMT and paramedic; and

1222 (3) Practice under the supervision of a medical director.

1223 (c) An individual providing patient care in a remote state under the

1224 privilege to practice shall function within the scope of practice
1225 authorized by the home state unless and until modified by an
1226 appropriate authority in the remote state as may be defined in the rules
1227 of the Commission.

1228 (d) Except as provided in subsection (c) of this section, an individual
1229 practicing in a remote state shall be subject to the remote state's
1230 authority and laws. A remote state may, in accordance with due process
1231 and that state's laws, restrict, suspend or revoke an individual's
1232 privilege to practice in the remote state and may take any other
1233 necessary actions to protect the health and safety of its citizens. If a
1234 remote state takes action, it shall promptly notify the home state and the
1235 Commission.

1236 (e) If an individual's license in any home state is restricted or
1237 suspended, the individual shall not be eligible to practice in a remote
1238 state under the privilege to practice until the individual's home state
1239 license is restored.

1240 (f) If an individual's privilege to practice in any remote state is
1241 restricted, suspended or revoked, the individual shall not be eligible to
1242 practice in any remote state until the individual's privilege to practice is
1243 restored.

1244 SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

1245 An individual may practice in a remote state under a privilege to
1246 practice only in the performance of the individual's EMS duties as
1247 assigned by an appropriate authority, as defined in the rules of the
1248 Commission, and under the following circumstances:

1249 (1) The individual originates a patient transport in a home state and
1250 transports the patient to a remote state;

1251 (2) The individual originates in the home state and enters a remote
1252 state to pick up a patient and provide care and transport of the patient
1253 to the home state;

1254 (3) The individual enters a remote state to provide patient care or
1255 transport within that remote state;

1256 (4) The individual enters a remote state to pick up a patient and
1257 provide care and transport to a third member state; or

1258 (5) Other conditions as determined by rules promulgated by the
1259 Commission.

1260 SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT
1261 ASSISTANCE COMPACT

1262 Upon a member state's Governor's declaration of a state of emergency
1263 or disaster that activates the Emergency Management Assistance
1264 Compact (EMAC), all relevant terms and provisions of EMAC shall
1265 apply and to the extent any terms or provisions of this compact conflict
1266 with EMAC, the terms of EMAC shall prevail with respect to any
1267 individual practicing in the remote state in response to such declaration.

1268 SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING
1269 FROM ACTIVE-DUTY MILITARY AND THEIR SPOUSES

1270 (a) Member states shall consider a veteran, active military service
1271 member and member of the National Guard and Reserve separating
1272 from an active-duty tour, and a spouse thereof, who holds a current
1273 valid and unrestricted NREMT certification at or above the level of the
1274 state license being sought as satisfying the minimum training and
1275 examination requirements for such licensure.

1276 (b) Member states shall expedite the processing of licensure
1277 applications submitted by veterans, active military service members
1278 and members of the National Guard and Reserve separating from an
1279 active-duty tour, and their spouses.

1280 (c) All individuals functioning with a privilege to practice under this
1281 section shall remain subject to the adverse actions provisions of section
1282 8 of this compact.

1283 SECTION 8. ADVERSE ACTIONS

1284 (a) A home state shall have exclusive power to impose adverse action
1285 against an individual's license issued by the home state.

1286 (b) If an individual's license in any home state is restricted or
1287 suspended, the individual shall not be eligible to practice in a remote
1288 state under the privilege to practice until the individual's home state
1289 license is restored.

1290 (1) All home state adverse action orders shall include a statement that
1291 the individual's compact privileges are inactive. The order may allow
1292 the individual to practice in remote states with prior written
1293 authorization from both the home state and the remote state's EMS
1294 authority.

1295 (2) An individual currently subject to adverse action in the home state
1296 shall not practice in any remote state without prior written
1297 authorization from both the home state and the remote state's EMS
1298 authority.

1299 (c) A member state shall report adverse actions and any occurrences
1300 that the individual's compact privileges are restricted, suspended or
1301 revoked to the Commission in accordance with the rules of the
1302 Commission.

1303 (d) A remote state may take adverse action on an individual's
1304 privilege to practice within that state.

1305 (e) Any member state may take adverse action against an individual's
1306 privilege to practice in that state based on the factual findings of another
1307 member state, so long as each state follows its own procedures for
1308 imposing such adverse action.

1309 (f) A home state's EMS authority shall investigate and take
1310 appropriate action with respect to reported conduct in a remote state as
1311 it would if such conduct had occurred within the home state. In such
1312 cases, the home state's law shall control in determining the appropriate

1313 adverse action.

1314 (g) Nothing in this compact shall override a member state's decision
1315 that participation in an alternative program may be used in lieu of
1316 adverse action and that such participation shall remain nonpublic if
1317 required by the member state's laws. Member states shall require
1318 individuals who enter any alternative programs to agree not to practice
1319 in any other member state during the term of the alternative program
1320 without prior authorization from such other member state.

1321 SECTION 9. ADDITIONAL POWERS INVESTED IN A MEMBER
1322 STATE'S EMS AUTHORITY

1323 A member state's EMS authority, in addition to any other powers
1324 granted under state law, is authorized under this compact to:

1325 (1) Issue subpoenas for both hearings and investigations that require
1326 the attendance and testimony of witnesses and the production of
1327 evidence. Subpoenas issued by a member state's EMS authority for the
1328 attendance and testimony of witnesses or the production of evidence
1329 from another member state shall be enforced in the remote state by any
1330 court of competent jurisdiction according to that court's practice and
1331 procedure in considering subpoenas issued in its own proceedings. The
1332 issuing state's EMS authority shall pay any witness fees, travel expenses,
1333 mileage and other fees required by the service statutes of the state where
1334 the witnesses or evidence are located; and

1335 (2) Issue cease and desist orders to restrict, suspend or revoke an
1336 individual's privilege to practice in the state.

1337 SECTION 10. ESTABLISHMENT OF THE INTERSTATE
1338 COMMISSION FOR EMS PERSONNEL PRACTICE

1339 (a) The compact states hereby create and establish a joint public
1340 agency known as the Interstate Commission for EMS Personnel Practice.

1341 (1) The Commission is a body politic and an instrumentality of the
1342 compact states.

1343 (2) Venue is proper and judicial proceedings by or against the
1344 Commission shall be brought solely and exclusively in a court of
1345 competent jurisdiction where the principal office of the Commission is
1346 located. The Commission may waive venue and jurisdictional defenses
1347 to the extent it adopts or consents to participate in alternative dispute
1348 resolution proceedings.

1349 (3) Nothing in this compact shall be construed to be a waiver of
1350 sovereign immunity.

1351 (b) Membership, voting and meetings

1352 (1) Each member state shall have and be limited to one delegate. The
1353 responsible official of the state EMS authority, or such official's
1354 designee, shall be the delegate to this compact for each member state.
1355 Any delegate may be removed or suspended from office as provided by
1356 the law of the state from which the delegate is appointed. Any vacancy
1357 occurring in the Commission shall be filled in accordance with the laws
1358 of the member state in which the vacancy exists. In the event that more
1359 than one board, office or other agency with the legislative mandate to
1360 license EMS personnel at and above the level of EMT exists, the
1361 Governor of the state shall determine which entity will be responsible
1362 for assigning the delegate.

1363 (2) Each delegate shall be entitled to one vote with regard to the
1364 promulgation of rules and creation of bylaws and shall otherwise have
1365 an opportunity to participate in the business and affairs of the
1366 Commission. A delegate shall vote in person or by such other means as
1367 provided in the bylaws. The bylaws may provide for delegates'
1368 participation in meetings by telephone or other means of
1369 communication.

1370 (3) The Commission shall meet at least once during each calendar
1371 year. Additional meetings shall be held as set forth in the bylaws.

1372 (4) All meetings shall be open to the public, and public notice of
1373 meetings shall be given in the same manner as required under the

1374 rulemaking provisions in section 12 of this compact.

1375 (5) The Commission may convene in a closed, nonpublic meeting if
1376 the Commission intends to discuss:

1377 (A) Noncompliance of a member state with its obligations under the
1378 compact;

1379 (B) The employment, compensation, discipline or other personnel
1380 matters, practices or procedures related to specific employees or other
1381 matters related to the Commission's internal personnel practices and
1382 procedures;

1383 (C) Current, threatened or reasonably anticipated litigation;

1384 (D) Negotiation of contracts for the purchase or sale of goods, services
1385 or real estate;

1386 (E) Accusing any person of a crime or formally censuring any person;

1387 (F) Disclosure of trade secrets or commercial or financial information
1388 that is privileged or confidential;

1389 (G) Disclosure of information of a personal nature where disclosure
1390 would constitute a clearly unwarranted invasion of personal privacy;

1391 (H) Disclosure of investigatory records compiled for law enforcement
1392 purposes;

1393 (I) Disclosure of information related to any investigatory reports
1394 prepared by or on behalf of or for use of the Commission or other
1395 committee charged with responsibility of investigation or determination
1396 of compliance issues pursuant to the compact; or

1397 (J) Matters specifically exempted from disclosure by federal or
1398 member state statute.

1399 (6) If a meeting, or portion of a meeting, is closed pursuant to this
1400 provision, the Commission's legal counsel or designee shall certify that

1401 the meeting may be closed and shall reference each relevant exempting
1402 provision. The Commission shall keep minutes that fully and clearly
1403 describe all matters discussed in a meeting and shall provide a full and
1404 accurate summary of actions taken, and the reasons therefor, including
1405 a description of the views expressed. All documents considered in
1406 connection with an action shall be identified in such minutes. All
1407 minutes and documents of a closed meeting shall remain under seal,
1408 subject to release by a majority vote of the Commission or order of a
1409 court of competent jurisdiction.

1410 (c) (1) The Commission shall, by a majority vote of the delegates,
1411 prescribe bylaws or rules to govern its conduct as may be necessary or
1412 appropriate to carry out the purposes and exercise the powers of the
1413 compact, including, but not limited to:

1414 (A) Establishing the fiscal year of the Commission;

1415 (B) Providing reasonable standards and procedures (i) for the
1416 establishment and meetings of other committees, and (ii) governing any
1417 general or specific delegation of any authority or function of the
1418 Commission;

1419 (C) Providing reasonable procedures for calling and conducting
1420 meetings of the Commission, ensuring reasonable advance notice of all
1421 meetings and providing an opportunity for attendance of such meetings
1422 by interested parties, with enumerated exceptions designed to protect
1423 the public's interest, the privacy of individuals and proprietary
1424 information, including trade secrets. The Commission may meet in
1425 closed session only after a majority of the membership votes to close a
1426 meeting in whole or in part. As soon as practicable, the Commission
1427 shall make public a copy of the vote to close the meeting revealing the
1428 vote of each member with no proxy votes allowed;

1429 (D) Establishing the titles, duties and authority and reasonable
1430 procedures for the election of the officers of the Commission;

1431 (E) Providing reasonable standards and procedures for the

1432 establishment of the personnel policies and programs of the
1433 Commission. Notwithstanding any civil service or other similar laws of
1434 any member state, the bylaws shall exclusively govern the personnel
1435 policies and programs of the Commission;

1436 (F) Promulgating a code of ethics to address permissible and
1437 prohibited activities of Commission members and employees; and

1438 (G) Providing a mechanism for winding up the operations of the
1439 Commission and the equitable disposition of any surplus funds that
1440 may exist after the termination of the compact and after the payment or
1441 reserving of all of its debts and obligations.

1442 (2) The Commission shall publish its bylaws and file a copy thereof,
1443 and a copy of any amendment thereto, with the appropriate agency or
1444 officer in each of the member states, if any.

1445 (3) The Commission shall maintain its financial records in accordance
1446 with the bylaws.

1447 (4) The Commission shall meet and take such actions as are consistent
1448 with the provisions of this Compact and the bylaws.

1449 (d) The Commission shall have the following powers:

1450 (1) The authority to promulgate uniform rules to facilitate and
1451 coordinate implementation and administration of this compact. The
1452 rules shall have the force and effect of law and shall be binding in all
1453 member states;

1454 (2) To bring and prosecute legal proceedings or actions in the name
1455 of the Commission, provided the standing of any state EMS authority or
1456 other regulatory body responsible for EMS personnel licensure to sue or
1457 be sued under applicable law shall not be affected;

1458 (3) To purchase and maintain insurance and bonds;

1459 (4) To borrow, accept or contract for services of personnel, including,

1460 but not limited to, employees of a member state;

1461 (5) To hire employees, elect or appoint officers, fix compensation,
1462 define duties and grant such individuals appropriate authority to carry
1463 out the purposes of the compact and to establish the Commission's
1464 personnel policies and programs relating to conflicts of interest,
1465 qualifications of personnel and other related personnel matters;

1466 (6) To accept any and all appropriate donations and grants of money,
1467 equipment, supplies, materials and services and to receive, utilize and
1468 dispose of the same, provided at all times the Commission shall strive
1469 to avoid any appearance of impropriety or conflict of interest;

1470 (7) To lease, purchase, accept appropriate gifts or donations of or
1471 otherwise to own, hold, improve or use any property, real, personal or
1472 mixed, provided at all times the Commission shall strive to avoid any
1473 appearance of impropriety;

1474 (8) To sell, convey, mortgage, pledge, lease, exchange, abandon or
1475 otherwise dispose of any property, real, personal or mixed;

1476 (9) To establish a budget and make expenditures;

1477 (10) To borrow money;

1478 (11) To appoint committees, including advisory committees,
1479 comprised of members, state regulators, state legislators or their
1480 representatives and consumer representatives, and such other
1481 interested persons as may be designated in this compact and the bylaws;

1482 (12) To provide and receive information from, and to cooperate with,
1483 law enforcement agencies;

1484 (13) To adopt and use an official seal; and

1485 (14) To perform such other functions as may be necessary or
1486 appropriate to achieve the purposes of this compact consistent with the
1487 state regulation of EMS personnel licensure and practice.

1488 (e) Financing of the Commission

1489 (1) The Commission shall pay, or provide for the payment of, the
1490 reasonable expenses of its establishment, organization and ongoing
1491 activities.

1492 (2) The Commission may accept any and all appropriate revenue
1493 sources, donations and grants of money, equipment, supplies, materials
1494 and services.

1495 (3) The Commission may levy on and collect an annual assessment
1496 from each member state or impose fees on other parties to cover the cost
1497 of the operations and activities of the Commission and its staff, which
1498 shall be in a total amount sufficient to cover its annual budget as
1499 approved each year for which revenue is not provided by other sources.
1500 The aggregate annual assessment amount shall be allocated based upon
1501 a formula to be determined by the Commission, which shall promulgate
1502 a rule binding upon all member states.

1503 (4) The Commission shall not incur obligations of any kind prior to
1504 securing the funds adequate to meet the same, nor shall the Commission
1505 pledge the credit of any of the member states, except by and with the
1506 authority of the member state.

1507 (5) The Commission shall keep accurate accounts of all receipts and
1508 disbursements. The receipts and disbursements of the Commission shall
1509 be subject to the audit and accounting procedures established under its
1510 bylaws. However, all receipts and disbursements of funds handled by
1511 the Commission shall be audited yearly by a certified or licensed public
1512 accountant and the report of the audit shall be included in and become
1513 part of the annual report of the Commission.

1514 (f) Qualified immunity, defense and indemnification

1515 (1) The members, officers, executive director, employees and
1516 representatives of the Commission shall be immune from suit and
1517 liability, either personally or in their official capacity, for any claim for

1518 damage to or loss of property or personal injury or other civil liability
1519 caused by or arising out of any actual or alleged act, error or omission
1520 that occurred, or that the person against whom the claim is made had a
1521 reasonable basis for believing occurred, within the scope of Commission
1522 employment, duties or responsibilities, provided nothing in this
1523 subdivision shall be construed to protect any such person from suit or
1524 liability for any damage, loss, injury or liability caused by the intentional
1525 or wilful or wanton misconduct of that person.

1526 (2) The Commission shall defend any member, officer, executive
1527 director, employee or representative of the Commission in any civil
1528 action seeking to impose liability arising out of any actual or alleged act,
1529 error or omission that occurred within the scope of Commission
1530 employment, duties or responsibilities, or that the person against whom
1531 the claim is made had a reasonable basis for believing occurred within
1532 the scope of Commission employment, duties or responsibilities,
1533 provided nothing herein shall be construed to prohibit that person from
1534 retaining his or her own counsel, and, provided further, the actual or
1535 alleged act, error or omission did not result from that person's
1536 intentional or wilful or wanton misconduct.

1537 (3) The Commission shall indemnify and hold harmless any member,
1538 officer, executive director, employee or representative of the
1539 Commission for the amount of any settlement or judgment obtained
1540 against that person arising out of any actual or alleged act, error or
1541 omission that occurred within the scope of Commission employment,
1542 duties or responsibilities, or that such person had a reasonable basis for
1543 believing occurred within the scope of Commission employment, duties
1544 or responsibilities, provided the actual or alleged act, error or omission
1545 did not result from the intentional or wilful or wanton misconduct of
1546 that person.

1547 SECTION 11. COORDINATED DATABASE

1548 (a) The Commission shall provide for the development and
1549 maintenance of a coordinated database and reporting system containing

1550 licensure, adverse action and significant investigatory information on
1551 all licensed individuals in member states.

1552 (b) Notwithstanding any other provision of state law to the contrary,
1553 a member state shall submit a uniform data set to the coordinated
1554 database on all individuals to whom this compact is applicable as
1555 required by the rules of the Commission, including:

1556 (1) Identifying information;

1557 (2) Licensure data;

1558 (3) Significant investigatory information;

1559 (4) Adverse actions against an individual's license;

1560 (5) An indicator that an individual's privilege to practice is restricted,
1561 suspended or revoked;

1562 (6) Nonconfidential information related to alternative program
1563 participation;

1564 (7) Any denial of application for licensure and the reason or reasons
1565 for such denial; and

1566 (8) Other information that may facilitate the administration of this
1567 compact, as determined by the rules of the Commission.

1568 (c) The coordinated database administrator shall promptly notify all
1569 member states of any adverse action taken against, or significant
1570 investigative information on, any individual in a member state.

1571 (d) Member states contributing information to the coordinated
1572 database may designate information that shall not be shared with the
1573 public without the express permission of the contributing state.

1574 (e) Any information submitted to the coordinated database that is
1575 subsequently required to be expunged by the laws of the member state
1576 contributing the information shall be removed from the coordinated

1577 database.

1578 SECTION 12. RULEMAKING

1579 (a) The Commission shall exercise its rulemaking powers pursuant to
1580 the criteria set forth in this section and the rules adopted thereunder.
1581 Rules and amendments shall become binding as of the date specified in
1582 each rule or amendment.

1583 (b) If a majority of the legislatures of the member states rejects a rule,
1584 by enactment of a statute or resolution in the same manner used to adopt
1585 the compact, such rule shall have no further force and effect in any
1586 member state.

1587 (c) Rules or amendments to the rules shall be adopted at a regular or
1588 special meeting of the Commission.

1589 (d) Prior to promulgation and adoption of a final rule or rules by the
1590 Commission, and at least sixty days in advance of the meeting at which
1591 the rule will be considered and voted upon, the Commission shall file a
1592 Notice of Proposed Rulemaking:

1593 (1) On the Internet web site of the Commission; and

1594 (2) On the Internet web site of each member state's EMS authority or
1595 in the publication in which each state would otherwise publish
1596 proposed rules.

1597 (e) The Notice of Proposed Rulemaking shall include:

1598 (1) The proposed time, date and location of the meeting in which the
1599 rule will be considered and voted upon;

1600 (2) The text of the proposed rule or amendment and the reason for
1601 the proposed rule;

1602 (3) A request for comments on the proposed rule from any interested
1603 person; and

1604 (4) The manner in which interested persons may submit notice to the
1605 Commission of their intention to attend the public hearing and any
1606 written comments.

1607 (f) Prior to adoption of a proposed rule, the Commission shall allow
1608 persons to submit written data, facts, opinions and arguments, which
1609 shall be made available to the public.

1610 (g) The Commission shall grant an opportunity for a public hearing
1611 before it adopts a rule or amendment if a hearing is requested by:

1612 (1) At least twenty-five persons;

1613 (2) A governmental subdivision or agency; or

1614 (3) An association having at least twenty-five members.

1615 (h) If a hearing is held on the proposed rule or amendment, the
1616 Commission shall publish the place, time and date of the scheduled
1617 public hearing.

1618 (1) All persons wishing to be heard at the hearing shall notify the
1619 executive director of the Commission or other designated member in
1620 writing of their desire to appear and testify at the hearing not less than
1621 five business days before the scheduled date of the hearing.

1622 (2) Hearings shall be conducted in a manner providing each person
1623 who wishes to comment a fair and reasonable opportunity to comment
1624 orally or in writing.

1625 (3) No transcript of the hearing is required, unless a written request
1626 for a transcript is made, in which case the person requesting the
1627 transcript shall bear the cost of producing the transcript. A recording
1628 may be made in lieu of a transcript under the same terms and conditions
1629 as a transcript. This subdivision shall not preclude the Commission from
1630 making a transcript or recording of the hearing if it so chooses.

1631 (4) Nothing in this section shall be construed as requiring a separate

1632 hearing on each rule. Rules may be grouped for the convenience of the
1633 Commission at hearings required by this section.

1634 (i) Following the scheduled hearing date, or by the close of business
1635 on the scheduled hearing date if the hearing was not held, the
1636 Commission shall consider all written and oral comments received.

1637 (j) The Commission shall, by majority vote of all members, take final
1638 action on the proposed rule and shall determine the effective date of the
1639 rule, if any, based on the rulemaking record and the full text of the rule.

1640 (k) If no written notice of intent to attend the public hearing by
1641 interested parties is received, the Commission may proceed with
1642 promulgation of the proposed rule without a public hearing.

1643 (l) Upon determination that an emergency exists, the Commission
1644 may consider and adopt an emergency rule without prior notice,
1645 opportunity for comment or hearing, provided the usual rulemaking
1646 procedures provided in the compact and in this section shall be
1647 retroactively applied to the rule as soon as reasonably possible, in no
1648 event later than ninety days after the effective date of the rule. For the
1649 purposes of this provision, an emergency rule is one that must be
1650 adopted immediately in order to:

1651 (1) Meet an imminent threat to public health, safety or welfare;

1652 (2) Prevent a loss of Commission or member state funds;

1653 (3) Meet a deadline for the promulgation of an administrative rule
1654 that is established by federal law or rule; or

1655 (4) Protect public health and safety.

1656 (m) The Commission or an authorized committee of the Commission
1657 may direct revisions to a previously adopted rule or amendment for
1658 purposes of correcting typographical errors, errors in format, errors in
1659 consistency or grammatical errors. Public notice of any revisions shall
1660 be posted on the Internet web site of the Commission. The revision shall

1661 be subject to challenge by any person for a period of thirty days after
1662 posting. The revision may be challenged only on grounds that the
1663 revision results in a material change to a rule. A challenge shall be made
1664 in writing and delivered to the chair of the Commission prior to the end
1665 of the notice period. If no challenge is made, the revision will take effect
1666 without further action. If the revision is challenged, the revision shall
1667 not take effect without the approval of the Commission.

1668 SECTION 13. OVERSIGHT, DISPUTE RESOLUTION AND
1669 ENFORCEMENT

1670 (a) Oversight

1671 (1) The executive, legislative and judicial branches of state
1672 government in each member state shall enforce this compact and take
1673 all actions necessary and appropriate to effectuate the compact's
1674 purposes and intent. The provisions of this compact and the rules
1675 promulgated hereunder shall have standing as statutory law.

1676 (2) All courts shall take judicial notice of the compact and the rules in
1677 any judicial or administrative proceeding in a member state pertaining
1678 to the subject matter of this compact that may affect the powers,
1679 responsibilities or actions of the Commission.

1680 (3) The Commission shall be entitled to receive service of process in
1681 any such proceeding and shall have standing to intervene in such a
1682 proceeding for all purposes. Failure to provide service of process to the
1683 Commission shall render a judgment or order void as to the
1684 Commission, this compact or promulgated rules.

1685 (b) Default, technical assistance and termination

1686 (1) If the Commission determines that a member state has defaulted
1687 in the performance of its obligations or responsibilities under this
1688 compact or the promulgated rules, the Commission shall:

1689 (A) Provide written notice to the defaulting state and other member
1690 states of the nature of the default, the proposed means of curing the

1691 default and any other action to be taken by the Commission; and

1692 (B) Provide remedial training and specific technical assistance
1693 regarding the default.

1694 (2) If a state in default fails to cure the default, the defaulting state
1695 may be terminated from the compact upon an affirmative vote of a
1696 majority of the member states, and all rights, privileges and benefits
1697 conferred by this compact may be terminated on the effective date of
1698 termination. A cure of the default does not relieve the offending state of
1699 obligations or liabilities incurred during the period of default.

1700 (3) Termination of membership in the compact shall be imposed only
1701 after all other means of securing compliance have been exhausted.
1702 Notice of intent to suspend or terminate shall be given by the
1703 Commission to the Governor and the majority and minority leaders of
1704 the defaulting state's legislature, and each of the member states.

1705 (4) A state that has been terminated is responsible for all assessments,
1706 obligations and liabilities incurred through the effective date of
1707 termination, including obligations that extend beyond the effective date
1708 of termination.

1709 (5) The Commission shall not bear any costs related to a state that is
1710 found to be in default or that has been terminated from the compact,
1711 unless agreed upon in writing between the Commission and the
1712 defaulting state.

1713 (6) The defaulting state may appeal the action of the Commission by
1714 petitioning the United States District Court for the District of Columbia
1715 or the federal district where the Commission has its principal offices.
1716 The prevailing member shall be awarded all costs of such litigation,
1717 including reasonable attorney's fees.

1718 (c) Dispute resolution

1719 (1) Upon request by a member state, the Commission shall attempt to
1720 resolve disputes related to the compact that arise among member states

1721 and between member and nonmember states.

1722 (2) The Commission shall promulgate a rule providing for both
1723 mediation and binding dispute resolution for disputes as appropriate.

1724 (d) Enforcement

1725 (1) The Commission, in the reasonable exercise of its discretion, shall
1726 enforce the provisions and rules of this compact.

1727 (2) By majority vote, the Commission may initiate legal action in the
1728 United States District Court for the District of Columbia or the federal
1729 district where the Commission has its principal offices against a member
1730 state in default to enforce compliance with the provisions of the compact
1731 and its promulgated rules and bylaws. The relief sought may include
1732 both injunctive relief and damages. In the event judicial enforcement is
1733 necessary, the prevailing member shall be awarded all costs of such
1734 litigation, including reasonable attorney's fees.

1735 (3) The remedies herein shall not be the exclusive remedies of the
1736 Commission. The Commission may pursue any other remedies
1737 available under federal or state law.

1738 SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE
1739 COMMISSION FOR EMS PERSONNEL PRACTICE AND
1740 ASSOCIATED RULES, WITHDRAWAL AND AMENDMENT

1741 (a) The compact shall come into effect on the date on which the
1742 compact statute is enacted into law in the tenth member state. The
1743 provisions, which become effective at that time, shall be limited to the
1744 powers granted to the Commission relating to assembly and the
1745 promulgation of rules. Thereafter, the Commission shall meet and
1746 exercise rulemaking powers necessary to the implementation and
1747 administration of the compact.

1748 (b) Any state that joins the compact subsequent to the Commission's
1749 initial adoption of the rules shall be subject to the rules as they exist on
1750 the date on which the compact becomes law in that state. Any rule that

1751 has been previously adopted by the Commission shall have the full force
1752 and effect of law on the day the compact becomes law in that state.

1753 (c) Any member state may withdraw from this compact by enacting
1754 a statute repealing the same.

1755 (1) A member state's withdrawal shall not take effect until six months
1756 after enactment of the repealing statute.

1757 (2) Withdrawal shall not affect the continuing requirement of the
1758 withdrawing state's EMS authority to comply with the investigative and
1759 adverse action reporting requirements of this act prior to the effective
1760 date of withdrawal.

1761 (d) Nothing contained in this compact shall be construed to
1762 invalidate or prevent any EMS personnel licensure agreement or other
1763 cooperative arrangement between a member state and a nonmember
1764 state that does not conflict with the provisions of this compact.

1765 (e) This compact may be amended by the member states. No
1766 amendment to this compact shall become effective and binding upon
1767 any member state until it is enacted into the laws of all member states.

1768 SECTION 15. CONSTRUCTION AND SEVERABILITY

1769 This compact shall be liberally construed so as to effectuate the
1770 purposes thereof. If this compact shall be held contrary to the
1771 constitution of any state member thereto, the compact shall remain in
1772 full force and effect as to the remaining member states. Nothing in this
1773 compact supersedes state law or rules related to licensure of EMS
1774 agencies.

1775 Sec. 29. (NEW) (*Effective October 1, 2026*) On and after one year after
1776 the date on which the Recognition of Emergency Medical Services
1777 Personnel Licensure Interstate Compact is enacted in at least one of the
1778 states of Massachusetts, New York or Rhode Island, in accordance with
1779 the provisions of section 28 of this act, the Commissioner of Public
1780 Health shall require any applicant for licensure or certification pursuant

1781 to the provisions of chapter 384d of the general statutes to submit to
1782 criminal history records checks, including state and national criminal
1783 history records checks, in accordance with the provisions of section 29-
1784 17a of the general statutes as a condition of licensure or certification.

1785 Sec. 30. (NEW) (*Effective October 1, 2026*) Not later than five years after
1786 the date on which the provisions of section 28 of this act are
1787 implemented, the Commissioner of Public Health, in consultation with
1788 the Secretary of the Office of Policy and Management, shall submit a
1789 report on such implementation, in accordance with the provisions of
1790 section 11-4a of the general statutes, to the joint standing committee of
1791 the General Assembly having cognizance of matters relating to public
1792 health. Such report shall include an assessment on the impact of the
1793 implementation of such provisions on the state's emergency medical
1794 services workforce and patients' access to medical care and make
1795 recommendations to further support emergency medical services
1796 workforce development.

1797 Sec. 31. Subdivision (1) of subsection (c) of section 19a-37 of the 2026
1798 supplement to the general statutes is repealed and the following is
1799 substituted in lieu thereof (*Effective October 1, 2026*):

1800 (c) (1) Any laboratory or firm which conducts a water quality test on
1801 a private well serving a residential property or semipublic well in the
1802 state shall, not later than thirty days after the completion of such test,
1803 report the results of such test to the local health authority of the
1804 municipality where the property is located and the Department of
1805 Public Health in a format specified by the department. Results
1806 submitted to the Department of Public Health or the local health
1807 authority pursuant to this subsection, information obtained from any
1808 Department of Public Health or local health authority investigation
1809 regarding those results and any Department of Public Health or local
1810 health authority study of morbidity and mortality regarding the results
1811 shall be confidential pursuant to section 19a-25, except the local health
1812 authority and the department may [if approved by the commissioner,]
1813 disclose the results or information obtained from an investigation of the

1814 results to (A) the owner of the property on which the well is located, the
1815 owner of any other property that obtains water from the well, and the
1816 owner of each property that is adjacent to the property on which the
1817 well is located or to any other property that obtains water from the well,
1818 (B) a prospective buyer of such property who has signed a contract to
1819 purchase such property, (C) other persons or entities, when such
1820 disclosure is necessary to carry out a statutory or regulatory
1821 responsibility of the local health authority or department, [or] and (D)
1822 an agent of a state agency.

1823 Sec. 32. (NEW) (*Effective October 1, 2026*) Not later than January 1,
1824 2027, (1) the Division of Emergency Management and Homeland
1825 Security within the Department of Emergency Services and Public
1826 Protection, in consultation with the Departments of Housing, Social
1827 Services and Mental Health and Addiction Services, the 2-1-1 Infoline
1828 operated by the United Way of Connecticut, and the Connecticut
1829 Coalition to End Homelessness, shall develop guidance, in consultation
1830 with the Office of the Governor, the Office of Policy and Management
1831 and municipal leaders, regarding (A) extreme hot and cold weather
1832 protocols that may include, but need not limited to, weather factors,
1833 such as temperatures and wind chill, that will prompt the state and
1834 municipalities to open cooling centers and warming centers throughout
1835 the state, and (B) improvements to methods of communicating to the
1836 public during the activation of extreme hot and cold weather protocols,
1837 and (2) the Department of Housing, in consultation with the
1838 Departments of Social Services and Mental Health and Addiction
1839 Services, shall develop methods of improving outreach to unhoused
1840 individuals during extreme hot and cold weather events based on an
1841 evaluation conducted by the Department of Housing in conjunction
1842 with providers of services to such individuals.

1843 Sec. 33. Section 20-112a of the general statutes is repealed and the
1844 following is substituted in lieu thereof (*Effective October 1, 2026*):

1845 (a) As used in this section:

1846 (1) "Direct supervision" means a licensed dentist has authorized
1847 certain procedures to be performed on a patient by a dental assistant or
1848 an expanded function dental assistant with such dentist remaining on-
1849 site in the dental office or treatment facility while such procedures are
1850 being performed by the dental assistant or expanded function dental
1851 assistant and that, prior to the patient's departure from the dental office,
1852 such dentist reviews and approves the treatment performed by the
1853 dental assistant or expanded function dental assistant;

1854 (2) "Indirect supervision" means a licensed dentist is in the dental
1855 office or treatment facility, has personally diagnosed the condition,
1856 planned the treatment, authorized the procedures to be performed and
1857 remains in the dental office or treatment facility while the procedures
1858 are being performed by the dental assistant or expanded function dental
1859 assistant and evaluates the performance of the dental assistant or
1860 expanded function dental assistant;

1861 (3) "Dental assistant" means a person who: (A) Has (i) completed on-
1862 the-job training in dental assisting under direct supervision, (ii)
1863 successfully completed a dental assistant education program accredited
1864 by the American Dental Association's Commission on Dental
1865 Accreditation, or (iii) successfully completed a dental assistant
1866 education program that is accredited or recognized by any national or
1867 regional accrediting agency recognized by the United States
1868 Department of Education; and (B) meets any requirements established
1869 by the Commissioner of Public Health in regulations adopted pursuant
1870 to subsection (f) of this section;

1871 (4) "Expanded function dental assistant" means a dental assistant
1872 who has passed the Dental Assisting National Board's certified dental
1873 assistant or certified orthodontic assistant examination and then
1874 successfully completed: (A) An expanded function dental assistant
1875 program at an institution of higher education that is accredited by the
1876 Commission on Dental Accreditation of the American Dental
1877 Association that includes (i) educational courses relating to didactic and
1878 laboratory preclinical objectives for skills used by an expanded function

1879 dental assistant and that requires demonstration of such skills prior to
1880 advancing to clinical practice, (ii) not less than four hours of education
1881 in the area of ethics and professional standards for dental professionals,
1882 and (iii) a comprehensive clinical examination administered by the
1883 institution of higher education at the conclusion of such program; and
1884 (B) a comprehensive written examination concerning certified
1885 preventive functions and certified restorative functions administered by
1886 the Dental Assisting National Board; and

1887 (5) "Fluoride varnish treatment" means the application of a highly
1888 concentrated form of fluoride to the surface of the teeth.

1889 (b) Each expanded function dental assistant shall: (1) Maintain dental
1890 assistant or orthodontic assistant certification from the Dental Assisting
1891 National Board; (2) conspicuously display his or her dental assistant or
1892 orthodontic assistant certificate at his or her place of employment or
1893 place where he or she provides expanded function dental assistant
1894 services; (3) maintain professional liability insurance or other indemnity
1895 against liability for professional malpractice in an amount not less than
1896 five hundred thousand dollars for one person, per occurrence, with an
1897 aggregate liability of not less than one million five hundred thousand
1898 dollars while employed as an expanded function dental assistant; (4)
1899 provide expanded function dental assistant services only under direct
1900 or indirect supervision; and (5) meet any requirements established by
1901 the Commissioner of Public Health in regulations adopted pursuant to
1902 subsection (f) of this section.

1903 (c) (1) A licensed dentist may delegate to a dental [assistants] assistant
1904 such dental procedures as the dentist may deem advisable, including:
1905 (A) The taking of dental x-rays if the dental assistant can demonstrate
1906 successful completion of the dental radiation health and safety
1907 examination administered by the Dental Assisting National Board or a
1908 radiation health and safety competency assessment administered by a
1909 dental education program in the state that is accredited by the American
1910 Dental Association's Commission on Dental Accreditation; (B) the
1911 taking of impressions of teeth for study models; and (C) the provision

1912 of fluoride varnish treatments. [Such procedures] A dentist delegating
1913 the taking of dental x-rays pursuant to subparagraph (A) of this
1914 subdivision shall approve the taking of dental x-rays by the dental
1915 assistant and assume responsibility for such procedure, but need not
1916 remain on-site in the dental office or treatment facility while the dental
1917 assistant performs such procedure. The procedures described in
1918 subparagraphs (B) and (C) of this subdivision shall be performed under
1919 the direct supervision of a licensed dentist and the dentist providing
1920 direct supervision shall assume responsibility for such procedures.

1921 (2) A licensed dentist may delegate to an expanded function dental
1922 assistant such dental procedures as the dentist may deem advisable,
1923 including: (A) The placing, finishing and adjustment of temporary
1924 restorations and long-term individual fillings, capping materials and
1925 cement bases; (B) oral health education for patients; (C) dental sealants;
1926 (D) coronal polishing, provided the procedure is not represented or
1927 billed as prophylaxis; (E) administration of topical anesthetic under the
1928 direct supervision of the dentist prior to the administration of local
1929 anesthetic by a dentist or dental hygienist; and (F) taking alginate
1930 impressions of teeth, under the direct supervision of the dentist, for use
1931 in study models, orthodontic appliances, whitening trays, mouth
1932 guards or fabrication of temporary crowns. Such procedures shall be
1933 performed under either direct or indirect supervision, except as
1934 specifically provided in this subdivision, and the dentist providing such
1935 supervision shall assume responsibility for such procedures.

1936 (3) (A) No licensed dentist may delegate dental procedures to a dental
1937 assistant or expanded function dental assistant unless the dental
1938 assistant or expanded function dental assistant provides records
1939 demonstrating successful completion of the Dental Assisting National
1940 Board's infection control examination or an infection control
1941 competency assessment administered by a dental education program in
1942 the state that is accredited by the American Dental Association's
1943 Commission on Dental Accreditation, except as provided in subdivision
1944 (2) of this subsection, (B) a dental assistant may receive not more than
1945 fifteen months of on-the-job training by a licensed dentist for purposes

1946 of preparing the dental assistant for the infection control examination or
1947 infection control competency assessment, and (C) any licensed dentist
1948 who delegates dental procedures to a dental assistant shall retain and
1949 make such records available for inspection upon request of the
1950 Department of Public Health.

1951 (4) On and after January 1, 2018, upon successful completion of the
1952 Dental Assisting National Board's infection control examination or an
1953 infection control competency assessment administered by a dental
1954 education program in the state that is accredited by the American Dental
1955 Association's Commission on Dental Accreditation, each dental
1956 assistant or expanded function dental assistant shall complete not less
1957 than one hour of training or education in infection control in a dental
1958 setting every two years, including, but not limited to, courses, including
1959 online courses, offered or approved by a dental school or another
1960 institution of higher education that is accredited or recognized by the
1961 Commission on Dental Accreditation, a regional accrediting
1962 organization, the American Dental Association or a state, district or local
1963 dental association or society affiliated with the American Dental
1964 Association or the American Dental Assistants Association.

1965 (d) Except as provided in subsection (c) of this section, under no
1966 circumstances may a dental assistant or expanded function dental
1967 assistant engage in: (1) Diagnosis for dental procedures or dental
1968 treatment; (2) the cutting or removal of any hard or soft tissue or
1969 suturing; (3) the prescribing of drugs or medications that require the
1970 written or oral order of a licensed dentist or physician; (4) the
1971 administration of local, parenteral, inhalation or general anesthetic
1972 agents in connection with any dental operative procedure; (5) the taking
1973 of any final impression of the teeth or jaws or the relationship of the
1974 teeth or jaws for the purpose of fabricating any appliance or prosthesis;
1975 or (6) the practice of dental hygiene as defined in section 20-126l.

1976 (e) Each licensed dentist employing or otherwise engaging the
1977 services of an expanded function dental assistant shall: (1) Prior to hiring
1978 or otherwise engaging the services of the expanded function dental

1979 assistant, verify that the expanded function dental assistant meets the
1980 requirements described in subdivision (4) of subsection (a) and
1981 subdivisions (1) and (3) of subsection (b) of this section; (2) maintain
1982 documentation verifying that the expanded function dental assistant
1983 meets such requirements on the premises where the expanded function
1984 dental assistant provides services; (3) make such documentation
1985 available to the Department of Public Health upon request; and (4)
1986 provide direct or indirect supervision to not more than two expanded
1987 function dental assistants who are providing services at one time or, if
1988 the dentist's practice is limited to orthodontics, provide direct or indirect
1989 supervision to not more than four expanded function dental assistants
1990 who are providing services at one time.

1991 (f) The Commissioner of Public Health, in consultation with the State
1992 Dental Commission, established pursuant to section 20-103a, may adopt
1993 regulations in accordance with the provisions of chapter 54 to
1994 implement the provisions of this section. Such regulations, if adopted,
1995 shall include, but need not be limited to, identification of the: (1) Specific
1996 types of procedures that may be performed by a dental assistant and an
1997 expanded function dental assistant, consistent with the provisions of
1998 this section; (2) appropriate number of didactic, preclinical and clinical
1999 hours or number of procedures to be evaluated for clinical competency
2000 for each skill employed by an expanded function dental assistant; and
2001 (3) the level of supervision, that may include direct or indirect
2002 supervision, that is required for each procedure to be performed by an
2003 expanded function dental assistant.

2004 Sec. 34. (NEW) (*Effective October 1, 2026*) (a) As used in this section,
2005 "cosmetic injection" means a nonsurgical procedure involving the
2006 injection of a substance, including, but not limited to, botulinum toxin
2007 or dermal filler, to alter or enhance a person's physical appearance.

2008 (b) A dentist licensed pursuant to chapter 379 of the general statutes
2009 who (1) has successfully completed an in-person hands-on training in
2010 the administration of cosmetic injections administered by a continuing
2011 education provider or program approved by the Commissioner of

2012 Public Health or accredited by a national professional accrediting body,
2013 and (2) maintains professional liability insurance that covers cosmetic
2014 injection procedures, may administer a cosmetic injection to a patient's
2015 face.

2016 (c) Nothing in this section shall be construed to authorize a dentist to
2017 administer injections into the tear trough, infraorbital hollow, eyelids,
2018 medial canthal region or other orbit-adjacent soft tissue for the purpose
2019 of periocular volumization or under-eye hollow correction, or into the
2020 forehead, glabella or eyebrows for the purpose of improved cosmesis.
2021 Nothing in this subsection shall be construed to prohibit a dentist from
2022 administering (1) a neuromodulator to the lateral canthal region,
2023 including for the treatment of lateral canthal rhytids; (2) an injection for
2024 the management of orofacial pain, temporomandibular disorders or
2025 other oromandibular conditions; or (3) dermal filler to the malar,
2026 zygomatic or midface region when the primary intended treatment site
2027 is the cheek or midface and the injection site remains inferior to the
2028 infraorbital rim.

2029 (d) A dentist shall not delegate the administration of cosmetic
2030 injections to any dental hygienist, dental assistant or other auxiliary
2031 personnel.

2032 (e) The Commissioner of Public Health may adopt regulations, in
2033 accordance with chapter 54 of the general statutes, to implement the
2034 provisions of this section, including, but not limited to, minimum
2035 training standards, approved training courses and patient safety
2036 requirements.

2037 Sec. 35. Subsection (a) of section 20-123 of the general statutes is
2038 repealed and the following is substituted in lieu thereof (*Effective October*
2039 *1, 2026*):

2040 (a) No person shall engage in the practice of dentistry unless he or
2041 she is licensed pursuant to the provisions of this chapter. The practice of
2042 dentistry or dental medicine is defined as the diagnosis, evaluation,
2043 prevention or treatment by surgical or other means, of an injury,

2044 deformity, disease or condition of the oral cavity or its contents, or the
2045 jaws or the associated structures of the jaws. The practice of dentistry
2046 does not include: (1) The treatment of dermatologic diseases or
2047 disorders of the skin or face; (2) the performance of microvascular free
2048 tissue transfer; (3) the treatment of diseases or disorders of the eye; (4)
2049 ocular procedures; (5) the performance of cosmetic surgery or other
2050 cosmetic procedures other than (A) those related to the oral cavity, its
2051 contents, or the jaws, or (B) the administration of a cosmetic injection
2052 pursuant to section 34 of this act; or (6) nasal or sinus surgery, other than
2053 that related to the oral cavity, its contents or the jaws.

2054 Sec. 36. Subsection (b) of section 20-126c of the general statutes is
2055 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2056 *2026*):

2057 (b) Except as otherwise provided in this section, a licensee applying
2058 for license renewal shall earn a minimum of twenty-five contact hours
2059 of continuing education within the preceding twenty-four-month
2060 period. Such continuing education shall (1) be in an area of the licensee's
2061 practice; (2) reflect the professional needs of the licensee in order to meet
2062 the health care needs of the public; and (3) include not less than one
2063 contact hour of training or education in (A) any three of the [ten] twelve
2064 mandatory topics for continuing education activities prescribed by the
2065 commissioner pursuant to this subdivision, (B) [for registration periods
2066 beginning on and after October 1, 2016,] infection control in a dental
2067 setting, and (C) prescribing controlled substances and pain
2068 management. [For registration periods beginning on and after October
2069 1, 2011, the] The Commissioner of Public Health, in consultation with
2070 the Dental Commission, shall on or before October 1, 2010, and
2071 biennially thereafter until October 1, 2026, issue a list that includes ten
2072 mandatory topics for continuing education activities that will be
2073 required for the following two-year registration period. For registration
2074 periods beginning on and after October 1, 2026, the commissioner, in
2075 consultation with said commission, shall on or before October 1, 2026,
2076 and biennially thereafter, issue a list that includes twelve mandatory
2077 topics, including, but not limited to, the provision of dental care to

2078 persons with an intellectual or developmental disability and identifying
 2079 victims of human trafficking, that will be required for the following two-
 2080 year registration period. Qualifying continuing education activities
 2081 include, but are not limited to, courses, including on-line courses,
 2082 offered or approved by the American Dental Association or state,
 2083 district or local dental associations and societies affiliated with the
 2084 American Dental Association; national, state, district or local dental
 2085 specialty organizations or the American Academy of General Dentistry;
 2086 a hospital or other health care institution; dental schools and other
 2087 schools of higher education accredited or recognized by the Council on
 2088 Dental Accreditation or a regional accrediting organization; agencies or
 2089 businesses whose programs are accredited or recognized by the Council
 2090 on Dental Accreditation; local, state or national medical associations; a
 2091 state or local health department; or the Accreditation Council for
 2092 Graduate Medical Education. Eight hours of volunteer dental practice
 2093 at a public health facility, as defined in section 20-126l, or a temporary
 2094 dental clinic may be substituted for one contact hour of continuing
 2095 education, up to a maximum of ten contact hours in one twenty-four-
 2096 month period.

2097 Sec. 37. Sections 17a-227d and 17a-476a of the general statutes are
 2098 repealed. (*Effective October 1, 2026*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2026</i>	19a-490(a)
Sec. 2	<i>July 1, 2026</i>	New section
Sec. 3	<i>July 1, 2026</i>	New section
Sec. 4	<i>October 1, 2026</i>	New section
Sec. 5	<i>from passage</i>	17b-338(a)
Sec. 6	<i>from passage</i>	19a-127l(d)
Sec. 7	<i>from passage</i>	19a-515(b)
Sec. 8	<i>from passage</i>	22a-430(g)
Sec. 9	<i>October 1, 2026</i>	20-200
Sec. 10	<i>from passage</i>	New section
Sec. 11	<i>October 1, 2026</i>	19a-127k(j)

Sec. 12	<i>October 1, 2026</i>	New section
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>July 1, 2026</i>	New section
Sec. 15	<i>July 1, 2026</i>	10-206
Sec. 16	<i>July 1, 2026</i>	10-206a
Sec. 17	<i>July 1, 2026</i>	19a-62a
Sec. 18	<i>October 1, 2026</i>	New section
Sec. 19	<i>from passage</i>	New section
Sec. 20	<i>from passage</i>	New section
Sec. 21	<i>July 1, 2027</i>	New section
Sec. 22	<i>from passage</i>	17b-59d(b)
Sec. 23	<i>October 1, 2027</i>	20-102aa
Sec. 24	<i>October 1, 2027</i>	20-102cc(a)
Sec. 25	<i>October 1, 2026</i>	19a-17(i)
Sec. 26	<i>from passage</i>	31-57e(f)
Sec. 27	<i>October 1, 2027</i>	20-102ee(a)
Sec. 28	<i>October 1, 2026</i>	New section
Sec. 29	<i>October 1, 2026</i>	New section
Sec. 30	<i>October 1, 2026</i>	New section
Sec. 31	<i>October 1, 2026</i>	19a-37(c)(1)
Sec. 32	<i>October 1, 2026</i>	New section
Sec. 33	<i>October 1, 2026</i>	20-112a
Sec. 34	<i>October 1, 2026</i>	New section
Sec. 35	<i>October 1, 2026</i>	20-123(a)
Sec. 36	<i>July 1, 2026</i>	20-126c(b)
Sec. 37	<i>October 1, 2026</i>	Repealer section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 27 \$	FY 28 \$
UConn Health Ctr.	OF - Cost	Up to 113,500	Up to 113,500
UConn Health Ctr.	OF - See Below	See Below	See Below
Public Health, Dept.	GF - Revenue Gain	Potential Minimal	Potential Minimal
Public Health, Dept.	GF - Revenue Loss	See Below	See Below
Public Health, Dept.	GF - Potential Cost	Minimal	Minimal
Legislative Mgmt.	GF - Potential Cost	Minimal	Minimal
Department of Emergency Services and Public Protection	GF - Potential Cost	See Below	See Below
Mental Health & Addiction Serv., Dept.; Department of Developmental Services; Social Services, Dept.	GF - Potential Cost	See Below	See Below
Resources of the General Fund	GF - Potential Revenue Gain	See Below	See Below
Department of Emergency Services and Public Protection	Applicant Fingerprint Card Submission Account - Potential Revenue Gain	See Below	See Below

Note: GF=General Fund; OF=Operating Fund

Municipal Impact:

Municipalities	Effect	FY 27 \$	FY 28 \$
Various Municipal Police Departments	Potential Revenue Gain	See Below	See Below
Local and Regional School Districts	STATE MANDATE ¹ - Potential Cost	None	Potential Minimal

Explanation

The bill makes various changes to the public health statutes, resulting in the fiscal impacts described below.

Section 12 results in both a potential revenue loss and a potential savings, annually beginning in FY 27, to the UConn Health Center (UCHC). It allows hospital emergency departments to administer certain drugs to patients presenting with symptoms of substance use disorder without requiring in-patient admission. Any impacts will be half-year in FY 27 as the requirements take effect 1/1/27.

The bill may reduce the number of in-patient admissions to UCHC, to the extent that patients may have otherwise been admitted for this treatment. If a reduction in in-patient admissions occurs, the net impact will depend on the payer mix of those patients. A reduction in privately insured admissions would result in a revenue loss to UCHC, while a reduction in uninsured or underinsured admissions would result in a savings.

The bill additionally results in a potential cost to UCHC annually beginning in FY 27 by allowing UCHC to offer an opioid antagonist, or a prescription for an opioid antagonist, to patients presenting to the emergency department with symptoms of substance use disorder. To the extent that this increases the number of opioid antagonists provided

¹ State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

without payment from patients or insurance, there is a cost to UCHC of \$35 to \$50 per unit.²

The annualized ongoing fiscal impact would continue into the future subject to the number changes in UCHC inpatient admissions, the payer mix of those patients, and the number of opioid antagonists UCHC provides, if any.

Section 13 creates an endometriosis working group and allows members to be reimbursed for any necessary expenses incurred in the performance of their duties. This results in a potential minimal cost to the Office of Legislative Management beginning in FY 27 to the extent reimbursements are requested.

Section 14 establishes an advisory council on chimeric antigen receptor (CAR) T-cell therapy and other gene therapies within the Department of Public Health (DPH) for administrative purposes only. This results in a potential minimal cost to DPH beginning in FY 27, as council members may be reimbursed for necessary expenses incurred in performing their duties.

Additionally, the council may: (1) procure certain grants, gifts, bequests, sponsorships and in-kind donations for the purpose of carrying out its responsibilities; and (2) enter into any contracts or agreements necessary for the distribution or use of any received funds, services or property.

Sections 15 and 16 require high school student athletes to complete an athletics health assessment and local and regional boards of education (BOEs) to pay for the assessment for certain students, resulting in a potentially minimal cost to BOEs beginning in FY 28. The cost is dependent on the number of students for whom the BOE must pay for the assessment and the cost of the assessment. It is anticipated the cost of the assessment will be minimal and may be covered by

² A box of Narcan costs about \$35 to \$50 and contains two doses.

insurance for some students.

Section 18 results in a cost to the UConn Health Center (UCHC) of up to \$113,500 in both FY 27 and FY 28 and up to \$21,500 in FY 29. It requires the UCHC Health Disparities Institute to develop a menopause toolkit.

Given the scope of the project, it is anticipated that UCHC will incur staff costs in FY 27 and FY 28 of \$82,000 annually to hire a part-time Project Coordinator and a part-time Instructional Designer to complete the tool kit. UCHC will incur additional costs (in both FY 27 and FY 28) of up to \$31,500 for supplies and materials. It is anticipated UCHC will incur a cost of up to \$21,500 in FY 29 to update the toolkit.

Sections 24 and 25 expand DPH authority to take disciplinary action against nurse's aides and Rural Health Transformation (RHT) practitioners that commit specified misconduct, resulting in a potential minimal revenue gain³ to the General Fund beginning in FY 27.

Section 26 makes procedural changes that allow tribes to receive RHT Program funding without taking employment rights-related steps.

Section 28 enters Connecticut into the Emergency Medical Services (EMS) compact, resulting in a General Fund annual revenue loss⁴ of up to an estimated \$31,000 due to the loss of paramedic licensure renewal fees⁵ (\$155 each⁶) associated with individuals who are also licensed within other participating compact states. Of this total, \$1,000 is a

³ CGS Sec. 19a-17 gives DPH the authority to assess a civil penalty of up to \$25,000 to professionals under its jurisdiction as part of its disciplinary practices.

⁴ It is anticipated that DPH will receive up to 199 fewer paramedic renewals in the first year of joining the compact based on current DPH licenses held by paramedics in compact and neighboring states, assuming all neighbor states join the compact.

⁵ Paramedics are the only EMS provider license or certification covered by the compact with any associated fees in Connecticut. A conflict of provisions in PA 25-198 and PA 25-174 reconciled pursuant to CGS Sec. 2-30b eliminated the initial application fee, but not the renewal fee.

⁶ Of each \$155 renewal fee, \$150 is directly deposited into the General Fund. The remaining \$5 fee is deposited into the professional assistance program account which supports the Health Assistance InterVention Education Network (HAVEN).

revenue loss to the professional assistance program account that supports the Health Assistance InterVention Education Network (HAVEN). The revenue loss would begin one year after Massachusetts, New York, or Rhode Island enacts the EMS compact, and continue annually thereafter, as this triggers Connecticut's adoption of the compact.

The revenue loss may be partially offset to the extent Connecticut DPH charges a fee to out-of-state paramedics for granting compact privilege. Currently, the state does not directly charge a separate fee for privileges granted by any similar interstate occupational compacts.

Additionally, the EMS compact allows the United States EMS Compact Commission to levy an annual assessment on member states to cover the cost of its operations; however, such authority has never imposed any state assessments or fees. The Compact Commission is presently funded through a multi-year grant provided by the National Registry of EMTs.

Section 29 requires, beginning one year after a neighboring state enacts the EMS compact, applicants for EMS licensure and certification to submit to a state and national fingerprint-based criminal history records check, resulting in: (1) a potential cost to the Department of Emergency Services and Public Protection (DESPP), (2) a potential revenue gain to the General Fund,⁷ and (3) a potential revenue gain to the Applicant Fingerprint Card Submission Account and various municipal police departments.⁸ These fiscal impacts would further depend on the volume of license and certification applications subject to this requirement, which is unknown.⁹

⁷DESPP conducts state criminal history records checks for a fee of \$75. The revenue that is collected from this fee is deposited into the General Fund.

⁸ DESPP conducts fingerprinting for a fee of \$15 per person paid to the Applicant Fingerprint Card Submission Account. Municipal police departments may also conduct the required fingerprinting for state criminal history records checks and typically charge a fee of \$10 to \$15.

⁹ For context, DPH issued 2,375 new EMS licenses and certifications in FY 25.

The fiscal impacts identified above will continue in the future subject to the timing of a neighboring state joining the EMS compact and the number of criminal history records checks subsequently performed by DESPP and various municipal police departments for EMS applicants.

Section 37 may result in a cost to the state beginning in FY 27 associated with removing salary cost caps for purposes of contracting with certain providers.

Currently, when determining state payments to any organization or facility providing employment opportunities or day services, or services in a residential facility to persons referred there by the state, state statute limits the total cost allowance for the associated director's salary. The same limitation applies when determining the amount of any Department of Mental Health and Addiction Services grant to provide services to mentally ill persons. The bill could therefore result in a cost to the state to the extent agencies consider higher salary costs when contracting for relevant services.

House "A" strikes the underlying bill and its associated fiscal impact, resulting in the impacts described above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) when the EMS compact becomes effective and (2) inflation in nonprofit provider director salaries.

OLR Bill Analysis**sHB 5514 (as amended by House "A")******AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.***

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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)	<ul style="list-style-type: none"> • One House member • One Connecticut-licensed physician experienced in diagnosing and treating endometriosis • One representative of a federally qualified health center

<i>Appointing Authority</i>	<i>Member Qualifications</i>
	<ul style="list-style-type: none"> • One state resident diagnosed with endometriosis
Senate president pro tempore (4)	<ul style="list-style-type: none"> • One Senate member • One physician member of the American College of Obstetrics and Gynecology • One researcher affiliated with a Connecticut academic or research institution with expertise in endometriosis • One patient advocate with experience advocating on behalf of people with endometriosis
House minority leader (4)	<ul style="list-style-type: none"> • One House member • One pediatric or adolescent medicine physician currently practicing in the state • One expert in racial and health equity or representative of a community-based organization serving historically underserved populations • One representative of a state hospital association or a Connecticut hospital administrator
Senate minority leader (4)	<ul style="list-style-type: none"> • One Senate member • One representative of a school-based health center • One representative of a therapeutic or drug manufacturer experienced in endometriosis-related treatments • 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)	<ul style="list-style-type: none"> • One hematologist or oncologist serving adults • One specialist in emerging cellular and genetic therapy • One pharmacology expert • One patient advocate for conditions treated by gene therapy
Public Health Committee House chairperson (4)	<ul style="list-style-type: none"> • One patient who received CAR T-cell therapy • One representative of a Connecticut hospital association • One pediatric hematologist or oncologist • One community health equity advocate
Public Health Committee Senate ranking member (4)	<ul style="list-style-type: none"> • One representative of an internationally recognized accreditation body for institutions providing cellular therapies • One representative of a Connecticut health carrier association • One director of a Connecticut cellular therapy program • One representative of the life sciences or biotechnology industries
Public Health Committee House ranking member (4)	<ul style="list-style-type: none"> • One representative, family member, or caregiver of someone living with cancer who received gene therapy • One advocate for cancer patients in the state • One social worker or patient navigator • 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)