General Assembly

Amendment

February Session, 2026

LCO No. **4844**

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Offered by:
REP. MCCARTHY VAHEY, 133rd Dist.
SEN. ANWAR, 3rd Dist.

To: House Bill No. **5514** File No. 540 Cal. No. 359

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

Strike everything after the enacting clause and substitute the following in lieu thereof:

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 Subsection (a) of section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Subsection (a) of section 17b-338 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a Long-Term Care Advisory Council which shall consist of the following: (1) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee; (2) the State Nursing Home Ombudsman, or the ombudsman's designee; (3) the president of the Coalition of Presidents of Resident Councils, or the president's designee; (4) the executive director of the Legal Assistance Resource Center of Connecticut, or the executive director's designee; (5) the state president of AARP, or the president's designee; (6) one representative of a bargaining unit for health care employees, appointed by the president of the bargaining unit; (7) the president of LeadingAge Connecticut and Rhode Island, Inc., or the president's designee; (8) the president of the Connecticut Association of Health Care Facilities, or the president's designee; (9) the president of the Connecticut Association of Residential Care Homes, or the president's designee; (10) the president of the Connecticut Hospital Association or the president's designee; (11) the executive director of the Connecticut Assisted Living Association or the executive director's designee; (12) the executive director of the Connecticut Association for Homecare or the executive director's designee; (13) the president of Connecticut Community Care, Inc. or the president's designee; (14) one member of the Connecticut Association of Area Agencies on Aging appointed by the agency; (15) the president of the Connecticut chapter of the Connecticut Alzheimer's Association; (16) one member of the Connecticut Association of Adult Day Centers appointed by the association; (17) the president of the Connecticut Chapter of the American College of Health Care Administrators, or the president's designee; (18) the president of the Connecticut Council for Persons with Disabilities, or the president's designee; (19) the president of the Connecticut Association of Community Action Agencies, or the president's designee; (20) a personal care attendant appointed by the speaker of the House of Representatives; (21) a person who, in a home setting, cares for a person with a disability and is appointed by the

president pro tempore of the Senate; (22) three persons with a disability appointed one each by the majority leader of the House of Representatives, the majority leader of the Senate and the minority leader of the House of Representatives; (23) a legislator who is a member of the Long-Term Care Planning Committee; (24) one member who is a nonunion home health aide appointed by the minority leader of the Senate; and (25) the executive director of the nonprofit entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system or the executive director's designee.

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

(d) The advisory committee shall consist of (1) four members who represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by LeadingAge Connecticut and Rhode Island, Inc.; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the

Commissioner of Public Health; (11) the Commissioner of Public Health or said commissioner's designee; (12) the Commissioner of Social Services or said commissioner's designee; (13) the Secretary of the Office of Policy and Management or said secretary's designee; (14) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; (15) one member who represents and shall be appointed by the federally designated state peer review organization; and (16) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio nonvoting members in specialties not represented among voting members. Vacancies shall be filled by the person who makes the appointment under this subsection.

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

(b) Each licensee shall complete a minimum of forty hours of continuing education every two years, including, but not limited to, training in (1) Alzheimer's disease and dementia symptoms and care, and (2) infection prevention and control. Such two-year period shall commence on the first date of renewal of the licensee's license after January 1, 2004. The continuing education shall be in areas related to the licensee's practice. Qualifying continuing education activities are courses offered or approved by the Connecticut Association of Healthcare Facilities, LeadingAge Connecticut and Rhode Island, Inc., the Connecticut Assisted Living Association, the Connecticut Alliance for Subacute Care, Inc., the Connecticut Chapter of the American College of Health Care Administrators, the Association For Long Term Care Financial Managers, the Alzheimer's Association or any accredited college or university, or programs presented or approved by the National Continuing Education Review Service of the National

Association of Boards of Examiners of Long Term Care Administrators, the Association for Professionals in Infection Control and Epidemiology or by federal or state departments or agencies.

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

(g) (1) The commissioner shall, by regulation adopted prior to October 1, 1977, establish and define categories of discharges that constitute household and small commercial subsurface sewage disposal systems for which the commissioner shall delegate to the Commissioner of Public Health the authority to issue permits or approvals and to hold public hearings in accordance with this section, on and after said date. Not later than July 1, 2026, but only after the working group has convened pursuant to section 49 of public act 25-97* and consideration of the recommendations provided by such working group pursuant to said section, the commissioner shall post a notice of intent to amend such regulations on the eRegulations System to establish and define categories of discharges that constitute small community sewerage systems and household and small commercial subsurface sewage disposal systems. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to establish minimum requirements for small community sewerage systems and household and small commercial subsurface sewage disposal systems and procedures for the issuance of such permits or approvals by the local director of health or an environmental health specialist registered pursuant to chapter 395. The commissioner shall issue and update technical standards applicable to the design, installation, engineering and operation of on-site sewage disposal systems under the jurisdiction of the Department of Public Health. Such technical standards shall not be considered regulations of Connecticut state agencies, as defined in section 4-166. The commissioner may implement policies and procedures necessary to implement the provisions of this subsection while in the process of adopting such policies and procedures as

regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation of such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time final regulations are adopted in accordance with the provisions of chapter 54. As used in this subsection, small community sewerage systems and household and small commercial disposal systems shall include those subsurface sewage disposal systems with a capacity of ten thousand gallons per day or less. Notwithstanding any provision of the general statutes (1) the regulations adopted by the commissioner pursuant to this subsection that are in effect as of July 1, 2017, shall apply to household and small commercial subsurface sewage disposal systems with a capacity of seven thousand five hundred gallons per day or less, and (2) the regulations adopted by the commissioner pursuant to this subsection that are in effect on or after July 1, 2026, shall apply to small community sewerage systems, household systems and small commercial subsurface sewerage disposal systems with a capacity of ten thousand gallons per day or less. Any permit denied by the Commissioner of Public Health, or a director of health or registered environmental health specialist shall be subject to hearing and appeal in the manner provided in section 19a-229. Any permit granted by the Commissioner of Public Health, or a director of health or registered environmental health specialist on or after October 1, 1977, shall be deemed equivalent to a permit issued under subsection (b) of this section.

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

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

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

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

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

(a) (1) Notwithstanding the provisions of section 20-198, the Department of Public Health may issue a license by endorsement to any veterinarian of good professional character who is currently licensed and practicing in some other state or territory, having requirements for admission determined by the department to be at least equal to the requirements of this state, upon the payment of a fee of five hundred sixty-five dollars to said department. Notwithstanding the provisions of section 20-198, the department may, upon payment of a fee of five

hundred sixty-five dollars, issue a license without examination to a currently practicing, competent veterinarian in another state or territory who **[**(1)**]** (A) holds a current valid license in good professional standing issued after examination by another state or territory that maintains licensing standards which, except for examination, are commensurate with this state's standards, and **[**(2)**]** (B) has worked continuously as a licensed veterinarian in an academic or clinical setting in another state or territory for a period of not less than five years immediately preceding the application for licensure without examination. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. The department shall inform the board annually of the number of applications it receives for licensure under this section.

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

(b) Notwithstanding the provisions of section 20-198, the Department of Public Health may issue a temporary permit to an applicant who (1) is a graduate from a school located outside of the United States, its territories or Canada with a degree of doctor of veterinary medicine, or its equivalent, from a program acceptable to the American Veterinary Medical Association as required to receive certification by the Educational Commission for Foreign Veterinary Graduates, and (2) is

working toward receiving certification from the Educational Commission for Foreign Veterinary Graduates or Program for the Assessment of Veterinary Education Equivalence. Such temporary permit shall authorize the holder to practice veterinary medicine only under the direct supervision of a veterinarian who has been licensed under chapter 384 for not less than two years. Such temporary permit shall be valid for a period not to exceed two years after the date of issuance, except such temporary permit shall be renewable once for a period of two years if the applicant fails to receive certification from the Educational Commission for Foreign Veterinary Graduates or Program for the Assessment of Veterinary Education Equivalence within the first two-year period. No fee shall be required for the issuance or renewal of a temporary permit under this section. As used in this subsection, "direct supervision" means the licensed veterinarian is present in the office where the temporary permit holder is performing such holder's duties and immediately available to furnish assistance and direction to such holder throughout the performance of such duties.

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

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

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

(2) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a member of an association of

veterinarians in the state;

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

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

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

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

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

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

(NEW) (j) When conducting a community health needs assessment, each hospital shall, if warranted by data available to the hospital, consider including the nutritional needs of community members with diabetes and congestive heart failure and, to the extent permissible

under federal law, include such nutritional needs in the hospital's community health needs assessment.

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

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

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

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

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

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

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

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

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

(b) On and after January 1, 2027, each hospital licensed pursuant to chapter 368v of the general statutes (1) may, to the extent permitted under federal law, (A) administer buprenorphine or methadone to each patient presenting to the hospital's emergency department with symptoms of opioid use disorder without requiring the admission of the patient to the hospital for the sole purpose of such administration, provided (i) the administration of buprenorphine or methadone is clinically indicated, and (ii) the patient consents to such administration, (B) offer the patient a prescription for or a supply of an opioid antagonist at the time of such patient's discharge from the emergency department and, if the patient accepts the offer, provide the patient with such prescription or dispense an opioid antagonist to the patient, and (C) refer the patient to one or more community providers or opioid treatment programs that can provide continuity in the prescription of buprenorphine or administration of methadone, as applicable, and (2) may, if clinically indicated, dispense a supply of methadone to each such patient in accordance with the provisions of section 21 CFR 1306. If a hospital administers buprenorphine to a patient under this subsection, the hospital shall provide the patient, to the extent permitted by federal law, with a bridging prescription for buprenorphine for the anticipated time period during which the patient will be awaiting treatment from the community provider to which the hospital refers the patient. If a hospital administers or dispenses methadone to a patient under this subsection, the hospital shall provide the patient with a last-dose letter to provide to the local opioid treatment program to which the hospital refers the patient.

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

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

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

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

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

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

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

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

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

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

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

endometriosis;

(2) Four appointed by the president pro tempore of the Senate, (A) one of whom shall be a member of the Senate, (B) one of whom shall be a physician licensed pursuant to chapter 370 of the general statutes who is a member of the American College of Obstetricians and Gynecologists, (C) one of whom shall be a researcher affiliated with an academic or research institution in the state with expertise in endometriosis, and (D) one of whom shall be a patient advocate with experience advocating on behalf of individuals with endometriosis;

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

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

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

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

(7) The cochairpersons of the endometriosis data and biorepository

program established pursuant to section 10a-132f of the general statutes.

(c) Except for members of the General Assembly, members who represent state agencies and the cochairpersons of the endometriosis data and biorepository program, six of the members first appointed shall serve for a term of two years, six of such members shall serve for a term of three years and, thereafter, members shall serve for a term of two years. The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity shall determine which of the members first appointed shall serve for a term of two years and which of such members shall serve for a term of three years. Any vacancy shall be filled by the appointing authority not later than thirty calendar days after the appointment becomes vacant. Any member previously appointed to the working group may be reappointed. The members of the working group shall receive no compensation for their services but may be reimbursed for any necessary expenses incurred in the performance of their duties.

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

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

Sec. 14. (NEW) (*Effective July 1, 2026*) (a) There is established an advisory council on chimeric antigen receptor T-cell therapy and other gene therapies. The council shall advise and make recommendations to the Department of Public Health and other state agencies, as appropriate, regarding (1) the availability of chimeric antigen receptor T-cell therapy and other gene therapies in the state for the treatment of cancer, (2) safe, equitable and financially sustainable delivery of such therapies, (3) advanced training for clinical providers of such therapies, (4) long-term follow-up and vector safety for patients receiving such therapies, (5) the development of referral and management protocols for such therapies, (6) education for clinicians, patients and patients' relatives and caregivers regarding such therapies and such protocols, (7) advising patients and their relatives and caregivers regarding the cost and availability of insurance coverage for such therapies, (8) opportunities for coordinating with research collaborations, government agencies, including, but not limited to, the Centers for Medicare and Medicaid Services, accrediting bodies and national registries regarding such therapies, (9) the development of centers of excellence in the state for the delivery of such therapies, including, but not limited to, requiring accreditation of such centers, (10) the development of a state-wide referral network to ensure all eligible patients are matched with a center of excellence in the state, (11) the development of safety protocols to address complications experienced by patients receiving such therapies and other safety concerns, (12) methods of providing psychosocial support to patients receiving such therapies and their relatives and caregivers, and (13) methods of tracking patient outcomes with a focus on equity as it relates to diagnosis, race, ethnicity, geography and income.

(b) The council may perform the following functions:

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

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

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

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

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

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

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

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

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

(6) Four appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a patient who has received chimeric antigen receptor T-cell therapy, one of whom shall be a representative of an association of hospitals in the state, one of whom

shall be a pediatric hematologist or oncologist and one of whom shall be a community health equity advocate;

(7) Four appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a representative of an internationally recognized accreditation body for institutions providing cellular therapies, one of whom shall be a representative of an association of health carriers in the state, one of whom shall be the director of a cellular therapy program in the state and one of whom shall be a representative of the life sciences or biotechnology industry; and

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

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

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

(f) Not later than one year after the date of its first meeting, and annually thereafter, the council shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance regarding its findings and recommendations, including, but not limited to, (1) the council's activities, research findings and any recommendations for proposed legislative changes, and (2) any potential sources of funding for the council's activities, including, but not limited to, grants, donations, sponsorships or in-kind donations.

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

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

(a) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments pursuant to the provisions of this section. Such assessments shall be conducted by (1) a legally qualified practitioner of medicine, (2) an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, (3) a physician assistant, licensed pursuant to chapter 370, (4) a school medical advisor, or (5) a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base, to ascertain whether such pupil is suffering from any

physical disability tending to prevent such pupil from receiving the full benefit of school work and to ascertain whether such school work should be modified in order to prevent injury to the pupil or to secure for the pupil a suitable program of education. No health assessment shall be made of any pupil enrolled in the public schools unless such examination is made in the presence of the parent or guardian or in the presence of another school employee. The parent or guardian of such pupil shall receive prior written notice and shall have a reasonable opportunity to be present at such assessment or to provide for such assessment himself or herself. A local or regional board of education may deny continued attendance in public school to any pupil who fails to obtain the health assessments required under this section.

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

consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, that such tests are necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

(c) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments in either grade six or grade seven and in either grade nine or grade ten. The assessment shall include: (1) A physical examination **[**which**]** that shall include hematocrit or hemoglobin tests, height, weight, blood pressure, and, beginning with the 2003-2004 school year, a chronic disease assessment which shall include, but not be limited to, asthma as defined by the Commissioner of Public Health pursuant to subsection (c) of section 19a-62a, as amended by this act. The assessment form shall include (A) a check box for the provider conducting the assessment, as provided in subsection (a) of this section, to indicate an asthma diagnosis, (B) screening questions relating to appropriate public health concerns to be answered by the parent or guardian, and (C) screening questions to be answered by such provider; (2) an updating of immunizations as required under section 10-204a, provided a registered nurse may only update said immunizations pursuant to a written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378; (3) vision, hearing, postural and gross dental screenings; and (4) such other information including a health history as the physician feels is necessary and appropriate. The assessment shall also include tests for tuberculosis and sickle cell anemia or Cooley's anemia where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered

nurse, licensed pursuant to chapter 378.

(d) For the school year commencing July 1, 2027, and each school year thereafter, each local or regional board of education shall require each pupil enrolled in grades nine to twelve, inclusive, in the public schools to have an athletics health assessment prior to being permitted to participate in interscholastic athletics for each academic year. The athletics assessment shall include a physical examination that shall include screening for serious cardiac conditions that could lead to sudden cardiac death, which screening shall be performed in accordance with guidelines established by the American Heart Association, the American College of Cardiology or another organization focused on cardiovascular care in pediatric populations. The athletics assessment form shall include (1) a check box for the provider conducting the athletics assessment, as provided in subsection (a) of this section, to indicate any patient or family history of symptoms of such serious cardiac conditions, including, but not limited to, chest pain with exertion or unexplained syncope, and any family history of sudden cardiac death, (2) screening questions relating to a family history of such serious cardiac issues to be answered by the parent or guardian, including, but not limited to, chest pain with exertion, unexplained syncope, sudden cardiac arrest or sudden cardiac death, (3) any additional cardiac screening questions to be answered by such provider, as deemed necessary and appropriate by such provider, and (4) a check box for the provider conducting the athletics assessment to indicate whether the provider referred the pupil for any additional cardiac screening or treatment.

[(d)**]** (e) The results of each assessment done pursuant to this section and the results of screenings done pursuant to section 10-214, as amended by **[**this act**]** public act 26-1, shall be recorded on forms supplied by the State Board of Education. Each school nurse may reject such results submitted on forms other than the forms supplied by the State Board of Education and require the resubmission of such results on such forms supplied by the State Board of Education. An asthma

action plan shall be included with each assessment form that indicates an asthma diagnosis pursuant to subsections (b) and (c) of this section. Such information shall be included in the cumulative health record of each pupil and shall be kept on file in the school such pupil attends. If a pupil permanently leaves the jurisdiction of the board of education, the pupil's original cumulative health record shall be sent to the chief administrative officer of the school district to which such student moves. The board of education transmitting such health record shall retain a true copy. Each physician, advanced practice registered nurse, registered nurse, or physician assistant performing health assessments and screenings pursuant to this section and section 10-214, as amended by **[**this act**]** public act 26-1, shall completely fill out and sign each form and any recommendations concerning the pupil shall be in writing.

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

[(f)**]** (g) On and after October 1, 2017, each local or regional board of education shall report to the local health department and the Department of Public Health, on an triennial basis, the total number of pupils per school and per school district having a diagnosis of asthma (1) at the time of public school enrollment, (2) in grade six or seven, and (3) in grade nine or ten. The report shall contain the asthma information

collected as required under subsections (b) and (c) of this section and shall include pupil age, gender, race, ethnicity and school. Beginning on October 1, 2021, and every three years thereafter, the Department of Public Health shall review the asthma screening information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning asthma trends and distributions among pupils enrolled in the public schools. The report shall be submitted in accordance with the provisions of section 11-4a and shall include, but not be limited to, (A) trends and findings based on pupil age, gender, race, ethnicity, school and the education reference group, as determined by the Department of Education for the town or regional school district in which such school is located, and (B) activities of the asthma screening monitoring system maintained under section 19a-62a, as amended by this act.

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

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

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

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

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

Sec. 18. (NEW) (*Effective October 1, 2026*) (a) The University of Connecticut Health Center's Health Disparities Institute, in consultation with the Department of Public Health, persons who have experienced symptoms of perimenopause, menopause and postmenopause, and health care providers who treat persons with symptoms of perimenopause, menopause and postmenopause, shall develop, within available appropriations, a toolkit that provides practical, evidence-based and culturally appropriate guidance to health care providers in the state who are responsible for diagnosing or treating persons with symptoms of menopause, perimenopause or postmenopause, as determined by said institute, including, but not limited to, health care providers in the fields of obstetrics, gynecology, internal medicine, family medicine, emergency medicine, psychiatry, mental health, social work, dentistry, dental hygiene and community health, regarding best practices for screening, identification, clinical assessment, diagnosis and treatment of symptoms of menopause, perimenopause and postmenopause. Such guidance may include, but need not be limited to, (1) a comprehensive description of the symptoms of menopause, perimenopause and postmenopause, (2) evidence-based guidelines regarding the identification and treatment of such symptoms, including, but not limited to, the use of hormones, such as hormone replacement therapy and testosterone therapy, (3) the availability of insurance coverage for such therapies, and (4) short education modules regarding such guidance that would qualify as continuing education for such health care providers.

(b) Not later than June 1, 2028, The University of Connecticut Health Center's Health Disparities Institute shall distribute the toolkit

developed pursuant to subsection (a) of this section to such health care providers. Not later than January 1, 2029, the institute shall (1) evaluate any feedback received from such health care providers regarding the effectiveness of the toolkit, (2) revise the toolkit as necessary to address such feedback, and (3) distribute a revised toolkit, if any, to such health care providers.

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

(1) "Designated employee" means a school nurse or nurse practitioner appointed pursuant to section 10-212 of the general statutes, school nurse supervisor, school counselor, school social worker or school psychologist who a local or regional school board of education designates to access safety plans of minor patients transmitted by health care providers to a school district or school's secure messaging system account pursuant to the provisions of this section;

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

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

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

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

(6) "Secure messaging system" means a platform capable of sending

and receiving secure messages and may include a platform that complies with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information Technology.

(b) On and after April 1, 2027, each health care provider that prepares a safety plan for a minor patient who received inpatient behavioral health care treatment for a period not less than twelve consecutive days shall (1) review such safety plan with the minor patient if the health care provider believes such a review is medically appropriate, and (2) inquire as to whether the minor patient or minor patient's parent or legally authorized representative consents to sharing such safety plan with the minor patient's school. If the minor patient or minor patient's parent or legally authorized representative consents to sharing such safety plan with the minor patient's school, the health care provider shall obtain written consent from (A) the minor patient's parent or legally authorized representative, or (B) if the minor patient is sixteen years of age or older, such minor patient, and transmit such safety plan to the minor patient's school district or school (i) using a secure messaging system, or (ii) in a form and manner that complies with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and 45 CFR 160.101 to 45 CFR 164.534, inclusive, as amended from time to time.

(c) Nothing in this section shall be construed to (1) create a standard of medical care with respect to any minor patient, (2) require a health care provider to create a safety plan, (3) require a health care provider to release information to a parent or legally authorized representative if, pursuant to state or federal law, a minor patient may withhold such information from such minor patient's parent or legally authorized representative, including, but not limited to, information regarding pregnancy, abortion, contraceptives, human immunodeficiency virus or other sexually transmitted disease testing or treatment, mental health treatment or any other area of care that a health care provider has promised a minor patient that the health care provider will keep confidential, or (4) require a health care provider to transmit a safety

plan or provide any other information to any person in violation of the provisions of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time.

Sec. 20. (NEW) (*Effective from passage*) (a) On or before January 1, 2027, each local or regional board of education shall ensure that each school district or school, as determined by the board, (1) signs up for an organizational account on a secure messaging system, as defined in section 19 of this act, and (2) provides access to one or more designated employees, as defined in section 19 of this act, one of whom shall be a school nurse supervisor, as defined in section 19 of this act, to such organizational account for the purpose of accessing minor patient safety plans, as defined in section 19 of this act, transmitted by health care providers, pursuant to the provisions of section 19 of this act. A designated employee shall retain minor patient safety plans in a confidential file separate from any cumulative academic or health record, provided information contained in a minor patient safety plan may be used to provide appropriate interventions pursuant to an individualized education program or a plan pursuant to Section 504 of the Rehabilitation Act of 1973.

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

Sec. 21. (NEW) (*Effective July 1, 2027*) For the school year commencing

July 1, 2027, and each school year thereafter, each local and regional board of education shall provide guidance regarding the requirements of section 19 of this act for all new designated employees, as defined in section 19 of this act. The Department of Education shall develop and make available such guidance and training materials for use by each local and regional board of education. Such materials shall include instruction for using a secure messaging system for the purpose of accessing minor patient safety plans, as defined in section 19 of this act, transmitted by health care providers pursuant to the provisions of section 19 of this act.

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

(b) It shall be the goal of the State-wide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) provide patients with secure electronic access to their health information in accordance with 45 CFR 171; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; **[**and**]** (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information

Exchange; and (12) provide, within available appropriations, (A) a secure messaging system organizational account to each school district or school, as determined by each local and regional board of education, for the purposes of receiving minor patient safety plans pursuant to the provisions of section 19 of this act, and (B) access to such organizational account for designated employees, as defined in section 19 of this act, at no cost to such school district, school and designated employee.

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

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

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

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

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

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

[(3) "registration"**]** (5) "Registration" means a document issued by the Department of Public Health to a nurse's aide which certifies that such aide has satisfied the training and competency evaluation requirements

prescribed by the commissioner; **[**and has been found qualified for employment in a chronic and convalescent nursing home or rest home with nursing supervision;**]** and

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

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

(a) The Department of Public Health shall receive, investigate and prosecute complaints against individuals who are providing or have provided services as a nurse's aide in **[**a chronic and convalescent nursing home or rest home with nursing supervision**]** an institution, as defined in section 19a-490, as amended by this act. The grounds for complaint shall include **[**resident abuse, resident neglect,**]** (1) illegal, incompetent or negligent conduct in the provision of nursing or nursing-related services, (2) abuse of a resident, patient or client, (3) neglect of a resident, patient or client, (4) misappropriation of resident, patient or client property, and (5) fraud or deceit in obtaining or attempting to obtain a registration as a nurse's aide. A nurse's aide shall be given written notice by certified mail by the commissioner of any complaint against him or her. The department may summarily suspend a nurse's aide's ability to practice in advance of a final adjudication on a complaint or during the appeals process in accordance with subsection (c) of section 19a-17. A nurse's aide who wishes to appeal a complaint against him or her shall, not later than thirty days after the date of the mailing, file with the department a request in writing for a hearing to contest the complaint. The commissioner shall render a finding on such complaint, and, if a hearing is requested, it shall be conducted pursuant to chapter 54. The commissioner shall have the authority to take any action against a nurse's aide set forth in section 19a-17, as amended by this act, and to render a finding and enter such finding on the registry against an individual who is providing or has provided services as a nurse's aide, **[**in a chronic and convalescent nursing home or rest home

with nursing supervision,**]** without regard to whether such individual is on the registry or has obtained registration as a nurse's aide from the department.

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

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

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

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

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

(a) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, concerning the regulation of nurse's aides. Such regulations shall require a training program for nurse's aides of not less than one hundred hours. Not less than seventy-five of such hours shall include, but not be limited to, basic nursing skills, personal care skills, care of cognitively impaired **[**residents**]** patients, recognition of mental health and social service needs, basic restorative services and **[**residents'**]** patients' rights. Not less than twenty-five of such hours shall include, but not be limited to, specialized training in understanding and responding to challenging behaviors related to physical, psychiatric, psychosocial and cognitive disorders. On and after January 1, 2022, not less than two of such hours shall include (1) screening for post-traumatic stress disorder, risk of suicide,

depression and grief, and (2) suicide prevention training offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association or Connecticut League for Nursing, a specialty nursing society or equivalent organization in another jurisdiction, a hospital or other health care institution, a regionally accredited academic institution, or a state or local health department. The requirement described in subdivision (2) of this section may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 17a-52a.

Sec. 28. (NEW) (*Effective October 1, 2026*) The Recognition of Emergency Medical Services Personnel Licensure Interstate Compact shall be enacted into law and entered into by the state of Connecticut with any and all states legally joining therein in accordance with its terms not earlier than one year after the date on which such compact is enacted in at least one of the states of Massachusetts, New York or Rhode Island. The compact is substantially as follows:

RECOGNITION OF EMERGENCY MEDICAL SERVICES PERSONNEL LICENSURE INTERSTATE COMPACT

SECTION 1. PURPOSE

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

This compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel and that such state regulation shared

among the member states will best protect public health and safety. This compact is designed to achieve the following purposes and objectives:

(1) Increase public access to EMS personnel;

(2) Enhance the states' ability to protect the public's health and safety, especially patient safety;

(3) Encourage the cooperation of member states in the areas of EMS personnel licensure and regulation;

(4) Support licensing of military members who are separating from an active-duty tour and their spouses;

(5) Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action and significant investigatory information;

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

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

SECTION 2. DEFINITIONS

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

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

(2) "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws that may be imposed against licensed EMS personnel by a state EMS authority or state court, including, but not limited to, actions against an individual's license such

as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual's practice, letters of reprimand or admonition, fines, criminal convictions and state court judgments enforcing adverse actions by the state EMS authority.

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

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

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

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

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

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

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

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

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

(12) "Paramedic" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the

National EMS Education Standards and National EMS Scope of Practice Model.

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

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

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

(16) "Scope of practice" means defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute or court decision, it tends to represent the limits of services an individual may perform.

(17) "Significant investigatory information" means:

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

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

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

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

SECTION 3. HOME STATE LICENSURE

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

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

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

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

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

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

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

(5) Complies with the rules of the Commission.

SECTION 4. COMPACT PRIVILEGE TO PRACTICE

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

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

(1) Be at least eighteen years of age;

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

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

(c) An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the Commission.

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

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

(f) If an individual's privilege to practice in any remote state is

restricted, suspended or revoked, the individual shall not be eligible to practice in any remote state until the individual's privilege to practice is restored.

SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

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

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

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

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

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

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

SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT

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

SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING

FROM ACTIVE-DUTY MILITARY AND THEIR SPOUSES

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

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

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

SECTION 8. ADVERSE ACTIONS

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

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

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

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

authority.

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

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

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

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

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

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

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

(1) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of

evidence. Subpoenas issued by a member state's EMS authority for the attendance and testimony of witnesses or the production of evidence from another member state shall be enforced in the remote state by any court of competent jurisdiction according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state's EMS authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses or evidence are located; and

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

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

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

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

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

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

(b) Membership, voting and meetings

(1) Each member state shall have and be limited to one delegate. The responsible official of the state EMS authority, or such official's designee, shall be the delegate to this compact for each member state. Any delegate may be removed or suspended from office as provided by

the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the Governor of the state shall determine which entity will be responsible for assigning the delegate.

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

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

(4) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in section 12 of this compact.

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

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

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

(C) Current, threatened or reasonably anticipated litigation;

(D) Negotiation of contracts for the purchase or sale of goods, services

or real estate;

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

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

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

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

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

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

(6) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

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

(A) Establishing the fiscal year of the Commission;

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

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

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

(E) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any member state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

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

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

(2) The Commission shall publish its bylaws and file a copy thereof, and a copy of any amendment thereto, with the appropriate agency or

officer in each of the member states, if any.

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

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

(d) The Commission shall have the following powers:

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

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

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept or contract for services of personnel, including, but not limited to, employees of a member state;

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

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

(7) To lease, purchase, accept appropriate gifts or donations of or otherwise to own, hold, improve or use any property, real, personal or

mixed, provided at all times the Commission shall strive to avoid any appearance of impropriety;

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

(9) To establish a budget and make expenditures;

(10) To borrow money;

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

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

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

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

(e) Financing of the Commission

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

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

(3) The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which shall be in a total amount sufficient to cover its annual budget as

approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

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

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

(f) Qualified immunity, defense and indemnification

(1) The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities, provided nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or wilful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission

employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and, provided further, the actual or alleged act, error or omission did not result from that person's intentional or wilful or wanton misconduct.

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

SECTION 11. COORDINATED DATABASE

(a) The Commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure, adverse action and significant investigatory information on all licensed individuals in member states.

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

(1) Identifying information;

(2) Licensure data;

(3) Significant investigatory information;

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

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

(6) Nonconfidential information related to alternative program participation;

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

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

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

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

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

SECTION 12. RULEMAKING

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

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

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

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

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

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

(e) The Notice of Proposed Rulemaking shall include:

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

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

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

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

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

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

(1) At least twenty-five persons;

(2) A governmental subdivision or agency; or

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

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

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

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

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

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

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

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

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with

promulgation of the proposed rule without a public hearing.

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

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

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

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

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the Internet web site of the Commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision shall not take effect without the approval of the Commission.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

(a) Oversight

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

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

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

(b) Default, technical assistance and termination

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

(A) Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and any other action to be taken by the Commission; and

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

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

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

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

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

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

(c) Dispute resolution

(1) Upon request by a member state, the Commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

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

(d) Enforcement

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

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal

district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

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

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

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

(b) Any state that joins the compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the compact becomes law in that state.

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

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

(2) Withdrawal shall not affect the continuing requirement of the withdrawing state's EMS authority to comply with the investigative and

adverse action reporting requirements of this act prior to the effective date of withdrawal.

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

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

SECTION 15. CONSTRUCTION AND SEVERABILITY

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

Sec. 29. (NEW) (*Effective October 1, 2026*) On and after one year after the date on which the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact is enacted in at least one of the states of Massachusetts, New York or Rhode Island, in accordance with the provisions of section 28 of this act, the Commissioner of Public Health shall require any applicant for licensure or certification pursuant to the provisions of chapter 384d of the general statutes to submit to criminal history records checks, including state and national criminal history records checks, in accordance with the provisions of section 29-17a of the general statutes as a condition of licensure or certification.

Sec. 30. (NEW) (*Effective October 1, 2026*) Not later than five years after the date on which the provisions of section 28 of this act are implemented, the Commissioner of Public Health, in consultation with the Secretary of the Office of Policy and Management, shall submit a report on such implementation, in accordance with the provisions of

section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include an assessment on the impact of the implementation of such provisions on the state's emergency medical services workforce and patients' access to medical care and make recommendations to further support emergency medical services workforce development.

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

(c) (1) Any laboratory or firm which conducts a water quality test on a private well serving a residential property or semipublic well in the state shall, not later than thirty days after the completion of such test, report the results of such test to the local health authority of the municipality where the property is located and the Department of Public Health in a format specified by the department. Results submitted to the Department of Public Health or the local health authority pursuant to this subsection, information obtained from any Department of Public Health or local health authority investigation regarding those results and any Department of Public Health or local health authority study of morbidity and mortality regarding the results shall be confidential pursuant to section 19a-25, except the local health authority and the department may **[**, if approved by the commissioner,**]** disclose the results or information obtained from an investigation of the results to (A) the owner of the property on which the well is located, the owner of any other property that obtains water from the well, and the owner of each property that is adjacent to the property on which the well is located or to any other property that obtains water from the well, (B) a prospective buyer of such property who has signed a contract to purchase such property, (C) other persons or entities, when such disclosure is necessary to carry out a statutory or regulatory responsibility of the local health authority or department, **[**or**]** and (D) an agent of a state agency.

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

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

(a) As used in this section:

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

(2) "Indirect supervision" means a licensed dentist is in the dental

office or treatment facility, has personally diagnosed the condition, planned the treatment, authorized the procedures to be performed and remains in the dental office or treatment facility while the procedures are being performed by the dental assistant or expanded function dental assistant and evaluates the performance of the dental assistant or expanded function dental assistant;

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

(4) "Expanded function dental assistant" means a dental assistant who has passed the Dental Assisting National Board's certified dental assistant or certified orthodontic assistant examination and then successfully completed: (A) An expanded function dental assistant program at an institution of higher education that is accredited by the Commission on Dental Accreditation of the American Dental Association that includes (i) educational courses relating to didactic and laboratory preclinical objectives for skills used by an expanded function dental assistant and that requires demonstration of such skills prior to advancing to clinical practice, (ii) not less than four hours of education in the area of ethics and professional standards for dental professionals, and (iii) a comprehensive clinical examination administered by the institution of higher education at the conclusion of such program; and (B) a comprehensive written examination concerning certified preventive functions and certified restorative functions administered by the Dental Assisting National Board; and

(5) "Fluoride varnish treatment" means the application of a highly

concentrated form of fluoride to the surface of the teeth.

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

(c) (1) A licensed dentist may delegate to a dental **[**assistants**]** assistant such dental procedures as the dentist may deem advisable, including: (A) The taking of dental x-rays if the dental assistant can demonstrate successful completion of the dental radiation health and safety examination administered by the Dental Assisting National Board or a radiation health and safety competency assessment administered by a dental education program in the state that is accredited by the American Dental Association's Commission on Dental Accreditation; (B) the taking of impressions of teeth for study models; and (C) the provision of fluoride varnish treatments. **[**Such procedures**]** A dentist delegating the taking of dental x-rays pursuant to subparagraph (A) of this subdivision shall approve the taking of dental x-rays by the dental assistant and assume responsibility for such procedure, but need not remain on-site in the dental office or treatment facility while the dental assistant performs such procedure. The procedures described in subparagraphs (B) and (C) of this subdivision shall be performed under the direct supervision of a licensed dentist and the dentist providing direct supervision shall assume responsibility for such procedures.

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

(3) (A) No licensed dentist may delegate dental procedures to a dental assistant or expanded function dental assistant unless the dental assistant or expanded function dental assistant provides records demonstrating successful completion of the Dental Assisting National Board's infection control examination or an infection control competency assessment administered by a dental education program in the state that is accredited by the American Dental Association's Commission on Dental Accreditation, except as provided in subdivision (2) of this subsection, (B) a dental assistant may receive not more than fifteen months of on-the-job training by a licensed dentist for purposes of preparing the dental assistant for the infection control examination or infection control competency assessment, and (C) any licensed dentist who delegates dental procedures to a dental assistant shall retain and make such records available for inspection upon request of the Department of Public Health.

(4) On and after January 1, 2018, upon successful completion of the Dental Assisting National Board's infection control examination or an infection control competency assessment administered by a dental

education program in the state that is accredited by the American Dental Association's Commission on Dental Accreditation, each dental assistant or expanded function dental assistant shall complete not less than one hour of training or education in infection control in a dental setting every two years, including, but not limited to, courses, including online courses, offered or approved by a dental school or another institution of higher education that is accredited or recognized by the Commission on Dental Accreditation, a regional accrediting organization, the American Dental Association or a state, district or local dental association or society affiliated with the American Dental Association or the American Dental Assistants Association.

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

(e) Each licensed dentist employing or otherwise engaging the services of an expanded function dental assistant shall: (1) Prior to hiring or otherwise engaging the services of the expanded function dental assistant, verify that the expanded function dental assistant meets the requirements described in subdivision (4) of subsection (a) and subdivisions (1) and (3) of subsection (b) of this section; (2) maintain documentation verifying that the expanded function dental assistant meets such requirements on the premises where the expanded function dental assistant provides services; (3) make such documentation available to the Department of Public Health upon request; and (4) provide direct or indirect supervision to not more than two expanded

function dental assistants who are providing services at one time or, if the dentist's practice is limited to orthodontics, provide direct or indirect supervision to not more than four expanded function dental assistants who are providing services at one time.

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

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

(b) A dentist licensed pursuant to chapter 379 of the general statutes who (1) has successfully completed an in-person hands-on training in the administration of cosmetic injections administered by a continuing education provider or program approved by the Commissioner of Public Health or accredited by a national professional accrediting body, and (2) maintains professional liability insurance that covers cosmetic injection procedures, may administer a cosmetic injection to a patient's face.

(c) Nothing in this section shall be construed to authorize a dentist to administer injections into the tear trough, infraorbital hollow, eyelids, medial canthal region or other orbit-adjacent soft tissue for the purpose

of periocular volumization or under-eye hollow correction, or into the forehead, glabella or eyebrows for the purpose of improved cosmesis. Nothing in this subsection shall be construed to prohibit a dentist from administering (1) a neuromodulator to the lateral canthal region, including for the treatment of lateral canthal rhytids; (2) an injection for the management of orofacial pain, temporomandibular disorders or other oromandibular conditions; or (3) dermal filler to the malar, zygomatic or midface region when the primary intended treatment site is the cheek or midface and the injection site remains inferior to the infraorbital rim.

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

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

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

(a) No person shall engage in the practice of dentistry unless he or she is licensed pursuant to the provisions of this chapter. The practice of dentistry or dental medicine is defined as the diagnosis, evaluation, prevention or treatment by surgical or other means, of an injury, deformity, disease or condition of the oral cavity or its contents, or the jaws or the associated structures of the jaws. The practice of dentistry does not include: (1) The treatment of dermatologic diseases or disorders of the skin or face; (2) the performance of microvascular free tissue transfer; (3) the treatment of diseases or disorders of the eye; (4) ocular procedures; (5) the performance of cosmetic surgery or other cosmetic procedures other than (A) those related to the oral cavity, its

contents, or the jaws, or (B) the administration of a cosmetic injection pursuant to section 34 of this act; or (6) nasal or sinus surgery, other than that related to the oral cavity, its contents or the jaws.

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

(b) Except as otherwise provided in this section, a licensee applying for license renewal shall earn a minimum of twenty-five contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include not less than one contact hour of training or education in (A) any three of the **[**ten**]** twelve mandatory topics for continuing education activities prescribed by the commissioner pursuant to this subdivision, (B) **[**for registration periods beginning on and after October 1, 2016,**]** infection control in a dental setting, and (C) prescribing controlled substances and pain management. **[**For registration periods beginning on and after October 1, 2011, the**]** The Commissioner of Public Health, in consultation with the Dental Commission, shall on or before October 1, 2010, and biennially thereafter until October 1, 2026, issue a list that includes ten mandatory topics for continuing education activities that will be required for the following two-year registration period. For registration periods beginning on and after October 1, 2026, the commissioner, in consultation with said commission, shall on or before October 1, 2026, and biennially thereafter, issue a list that includes twelve mandatory topics, including, but not limited to, the provision of dental care to persons with an intellectual or developmental disability and identifying victims of human trafficking, that will be required for the following two-year registration period. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Dental Association or state, district or local dental associations and societies affiliated with the

American Dental Association; national, state, district or local dental specialty organizations or the American Academy of General Dentistry; a hospital or other health care institution; dental schools and other schools of higher education accredited or recognized by the Council on Dental Accreditation or a regional accrediting organization; agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation; local, state or national medical associations; a state or local health department; or the Accreditation Council for Graduate Medical Education. Eight hours of volunteer dental practice at a public health facility, as defined in section 20-126*l*, or a temporary dental clinic may be substituted for one contact hour of continuing education, up to a maximum of ten contact hours in one twenty-four-month period.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2026*	19a-490(a)
Sec. 2	*July 1, 2026*	New section
Sec. 3	*July 1, 2026*	New section
Sec. 4	*October 1, 2026*	New section
Sec. 5	*from passage*	17b-338(a)
Sec. 6	*from passage*	19a-127l(d)
Sec. 7	*from passage*	19a-515(b)
Sec. 8	*from passage*	22a-430(g)
Sec. 9	*October 1, 2026*	20-200
Sec. 10	*from passage*	New section
Sec. 11	*October 1, 2026*	19a-127k(j)
Sec. 12	*October 1, 2026*	New section
Sec. 13	*from passage*	New section
Sec. 14	*July 1, 2026*	New section
Sec. 15	*July 1, 2026*	10-206
Sec. 16	*July 1, 2026*	10-206a
Sec. 17	*July 1, 2026*	19a-62a
Sec. 18	*October 1, 2026*	New section

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