Government Relations
END OF SESSION REPORT

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CNA
2015 GOVERNMENT RELATIONS
END OF SESSION REPORT

The 2015 Legislative Session convened on January 7th and adjourned at midnight on June 3rd. At the beginning of session, Governor Malloy delivered his State of the State address along with his proposed biennium budget. Among the highlights was a major overhaul of the state transportation system and no tax increases. Due to the looming budget deficit, the Governor cut many state programs with social services taking the biggest hit. The Governor's agenda were just some of the issues that the legislature had to address during this five month session.

The General Assembly considered over 4,000 bills during this long and very challenging session. CNA presented testimony on many bills that affected the nursing industry. Those bills were considered in the Public Health, Judiciary, Education, Children's, Environment, and Insurance and Real Estate Committees. Some of the bills that passed include: reports of nurse staffing levels, establishing infant safe sleep practices, increases to DPH license renewal fees to fund HAVEN (the Health Assistance InterVention Education Network) and aligning the vision, hearing and postural screening requirements in schools with those of the American Academy of Pediatrics (AAP). Several other less significant bills with some interest to CNA were also passed. Listed below is a summary of the bills referenced above that were passed during the 2015 session.

The Legislature went into Special Session on June 29, 2015 to address budgetary issues. I have included a summary of the issues of interest to CNA that passed in the budget implementer bill during Special Session. If you would like additional information on any of the summaries that follow, or more information on bills that may not have been included, please do not hesitate to contact us.

As always, we appreciate the relationship between Brown Rudnick and CNA and we look forward to continuing to advocate on your behalf.

Bills of Importance to CNA which passed during the 2015 Session of the General Assembly:

Public Act 15-10—HB 5525

Signed by Governor

AN ACT CONCERNING CYTOMEGALOVIRUS

SUMMARY: Starting January 1, 2016, this act requires all health care institutions caring for newborn infants to test those who fail a newborn hearing screening for cytomegalovirus (CMV). It requires the testing to be done (1) within available appropriations and (2) as soon as is medically appropriate, unless, as allowed by law, their parents object on religious grounds.

Like existing law that requires these institutions to test newborn infants for cystic fibrosis, severe combined immunodeficiency disease, and critical congenital heart disease, the test for CMV is not part of the state's newborn screening program for genetic and metabolic disorders. That program, in addition to screening, directs parents of identified infants to counseling and treatment.

The act also requires health care institutions to report CMV cases confirmed by the screening to the Department of Public Health (DPH) in a form and manner the commissioner prescribes.

EFFECTIVE DATE: July 1, 2015

Public Act 15-203—HB 5903

Signed by Governor

AN ACT CONCERNING A STUDY OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

SUMMARY: This act requires the public health (DPH) commissioner to study chronic obstructive pulmonary disease (COPD) in consultation with the social services commissioner and representatives of the Connecticut Hospital Association and any other national patient organization with COPD expertise. The DPH commissioner must report on the study's results to the Public Health Committee by February 1, 2016.

The act also requires the DPH commissioner to post certain information about COPD on the department's website. This includes information from the Centers for Disease Control and Prevention and other information that she believes may help people with COPD when talking with their health care providers about the disease.

COPD is a group of diseases, including emphysema and chronic bronchitis, that cause difficulty with airflow and breathing.

EFFECTIVE DATE: Upon passage

REPORT OF COPD STUDY

Under the act, the DPH commissioner's report must include:

1. hospitalization and 30-day readmission rates for state residents with COPD;

2. current activities by state agencies to promote awareness and education by health care providers and the general public on the disease, including its causes, the importance of early diagnosis using spirometry testing and treatment, effective prevention strategies, and disease management; and

3. an assessment of the need for community-based services for people with COPD.

In addition, the report must include recommendations on:

1. the necessity and feasibility of conducting a needs assessment with respect to COPD,

2. hosting an annual COPD summit,

3. developing a pilot program to determine best practices and outcomes and to lower hospital readmission rates, and

4. identifying the amount of funding and potential funding sources for the pilot program.

Special Act 15-8 - HB 5907

Signed by Governor

AN ACT CONCERNING SUPPLEMENTAL FIRST RESPONDERS

SUMMARY: The bill allows the Department of Public Health to issue a certificate of authorization for a supplemental first responder to an emergency medical services provider who operates only in a municipality with a population between 105,000 and 115,000. As there are no fees associated with the certificate, the bill has no fiscal impact.

Public Act 15-205—HB 6186

Signed by Governor

AN ACT PROTECTING SCHOOL CHILDREN

SUMMARY: This act increases, from a class A misdemeanor to a class E felony, the penalty for a mandated reporter who fails to report suspected child abuse or neglect to the Department of Children and Families (DCF) if the (1) violation is a subsequent violation; (2) violation is willful, intentional, or due to gross negligence; or (3) mandated reporter had actual knowledge of the abuse, neglect, or sexual assault (see Table on Penalties).

The act extends the mandated reporter law's protection to high school students age 18 and older who are not enrolled in an adult education program. It also expands the reporting requirement for school employees and subjects violators to the penalties described above. The act requires school employees to report to DCF suspected sexual assault of any student not enrolled in adult education by a school employee. It also establishes the factors on which all mandated reporters may base their suspicion. Under the act, it is a class D felony for anyone, other than a child or a student not enrolled in an adult

education program, to intentionally and unreasonably interfere with or prevent such reporting or conspire or attempt to do so (see Table on Penalties).

By law, (1) DCF must make available educational and refresher training to all mandated reporters of child abuse and neglect and (2) school employees must participate in the training when hired and every three years. Under the act, the principal for each school under the jurisdiction of a local or regional board of education must annually certify to the superintendent that school employees completed such training, and the superintendent must certify compliance to the State Board of Education (SBE).

The act extends DCF's investigation and notification requirements under existing law in reported child abuse or neglect cases to include cases of reported sexual assault of students by school employees.

It requires each local or regional board to (1) update its written policy, by February 1, 2016, to include the new school employee reporting requirements and (2) establish a confidential rapid response team, by January 1, 2016, to coordinate with DCF to ensure prompt reporting. It also prohibits the boards from hiring noncompliant or convicted employees who were terminated or resigned and requires SBE to revoke the certification, permit, or authorization of anyone convicted of certain crimes.

The act also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2015, except that the provisions regarding DCF's training program (§ 1); rapid response teams (§ 9); rehiring prohibitions (§ 10); and SBE's certification, authorization, and permit practices (§§ 12 & 13) take effect July 1, 2015.

Public Act 15-207—HB 6498

Signed by Governor

AN ACT CONCERNING EVIDENCE IN SEXUAL ASSAULT CASES

SUMMARY: This act makes various changes affecting evidence in sexual assault cases and establishes deadlines for transferring and processing sexual assault evidence police obtain from health care facilities that collect such evidence.

If an accused seeks to introduce evidence of a victim's sexual conduct in a sexual assault case, the act requires the hearing on the motion to be held in camera (i. e. , in private), rather than allowing the court to grant a motion to hold an in camera hearing at the request of either party. By law, evidence of a victim's sexual conduct in these cases is admissible only in certain limited circumstances.

The act requires motions, supporting documents, and related court documents concerning these hearings to be sealed and allows them to be unsealed only if the court rules that the evidence is admissible and the case goes to trial.

If the state discloses any such evidence, the act limits further disclosure of it by the defense counsel, the defendant, or agent of either.

EFFECTIVE DATE: October 1, 2015

MOTION ON ADMISSIBILITY OF EVIDENCE IN SEXUAL ASSAULT CASES

Under the act, any motion and supporting documents seeking to admit evidence of a victim's sexual conduct must be filed under seal. These documents may be unsealed only if the court rules that the evidence is admissible and the case proceeds to trial. If the court determines that only part of the evidence is admissible, only the pertinent part of the motion or documents may be unsealed. The court must maintain these documents under seal for delivery to the Appellate Court if the case is appealed.

The act sets similar requirements for the court regarding transcripts, records, and recordings of proceedings on these hearings. The court must seal them, and it may unseal them only if it rules that the evidence in the document or recording is admissible and the case proceeds to trial. If the court determines that only part of the evidence is admissible, it may unseal only the related portion of the document or recording.

The act specifically allows courts to set other terms and conditions applicable to such evidence of a victim's sexual conduct. For evidence disclosed by the state, the act prohibits the defendant, defense counsel, or agent of the defendant or defense counsel from further disclosing the evidence to anyone except people employed by the attorney in connection with the case investigation or defense, without the prior approval of the prosecutor or the court.

DEADLINES FOR PROCESSING AND TRANSFERRING SEXUAL ASSAULT EVIDENCE

By law, when a health care facility collects sexual assault evidence, it must “contact” a police department (in effect, provide the evidence to the police department), which must transfer the evidence to the state Division of Scientific Services or Federal Bureau of Investigation (FBI) laboratory (see BACKGROUND). Current law requires the agency that receives the evidence to hold it for 60 days. But if the victim reports the assault to the police, the agency must analyze the evidence at the request of the police department that transferred it, and the police department or agency must hold it until any criminal proceedings end.

The act adds transfer and processing deadlines for police departments and the division. Specifically, it requires a police department that receives sexual assault evidence from a health care facility to transfer the evidence to the Division of Scientific Services or the FBI within 10 days after the health care facility collects it.

If the evidence is transferred to the division, the act requires the division to analyze it within 60 days after it is collected, unless the victim chose to remain anonymous and not report the assault to the police at the time the evidence was collected, in which case the division must hold the evidence for at least five years after the collection. If the victim reports the assault to the police department after the evidence is collected, the department must notify the division of the report no later than five days after the victim files it, and the division must analyze the evidence no later than 60 days after getting the notification. By law, the agency must hold any evidence received and analyzed until the end of any criminal proceedings.

Under the act, a department's failure to transfer the evidence or the division's failure to process it within the deadlines does not affect the admissibility of the evidence in any suit, action, or proceeding if the evidence is otherwise admissible

Public Act 15-157—HB 6579

Signed by Governor

AN ACT CONCERNING DEVELOPMENTAL SCREENINGS FOR CHILDREN

SUMMARY: This act requires a health care provider, when completing the state's (1) early childhood health assessment record form ("yellow form") or (2) public school health assessment form ("blue form") for a child age five or younger, to indicate on the form whether he or she performed a developmental screening during the related examination.

Under the act, a developmental screening is one that uses a method recommended by the American Academy of Pediatrics to identify concerns with a child's physical and mental development, including the child's sensory, behavioral, motor, language, social, perceptual, or emotional skills.

EFFECTIVE DATE: July 1, 2015

Public Act 15-120—HB 6708

Signed by Governor

AN ACT CONCERNING VARIOUS REVISIONS TO THE MENTAL HEALTH AND ADDICTION STATUTES

SUMMARY: This act makes several changes in the Department of Mental Health and Addiction Services (DMHAS) statutes. It:

1. specifies that all private agencies treating psychiatric disabilities or substance abuse, regardless of whether they are state-funded, must comply with the commissioner's data collection requirements (§ 1);

2. authorizes the DMHAS commissioner to designate any employee, instead of only a deputy commissioner, to sign a contract, agreement, or settlement on the department's behalf (§ 2); and

3. repeals the commissioner's ability to appoint two deputy commissioners and a medical director but retains the provision allowing the commissioner to appoint any personnel necessary to carry out her duties (§§ 3-5).

The act also makes technical changes.

EFFECTIVE DATE: October 1, 2015

DATA COLLECTION

By law, the DMHAS commissioner must specify uniform methods for keeping statistical information for public and private agencies, including a client identifier system. The act specifies that these methods apply to all public and private agencies that provide care or

treatment for psychiatric disabilities or alcohol or drug abuse or dependence, including those agencies that are not state-operated or state-funded.

The act also specifies that the agencies or others involved in such treatment, and not the commissioner, must collect relevant statistical information and make it available. The act requires them to report the information to DMHAS in the form and manner the commissioner prescribes and upon her request. By law, this information includes the number of people treated, demographic and clinical information, frequency of admission and readmission, frequency and duration of treatment, level of care provided, and discharge and referral information.

Public Act 15-122—HB 6736

Signed by Governor

AN ACT EXTENDING TO OPTOMETRISTS THE PROHIBITION ON THE SETTING OF PAYMENTS BY HEALTH INSURERS AND OTHER ENTITIES FOR NONCOVERED BENEFITS

SUMMARY: This act prohibits a provider contract between an insurer and a licensed optometrist entered into, renewed, or amended on or after January 1, 2016 from requiring the optometrist to accept as payment an amount the insurer sets for services or procedures that are not covered benefits under an insurance policy or benefit plan.

Under the act, an "insurer" includes a health insurer, HMO, fraternal benefit society, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues an individual or group vision plan in Connecticut.

The act prohibits an optometrist from charging patients more than his or her usual and customary rate for services or procedures not covered by an insurance policy or benefit plan. It (1) requires an insurer to include a statement regarding noncovered services on each evidence of coverage document issued for individual or group vision plans and (2) specifies the language that must be included in the statement.

The act also requires optometrists to post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate.

The act does not apply to self-insured plans or collectively bargained agreements.

EFFECTIVE DATE: January 1, 2016

Public Act 15-125—HB 6796 **(VETOED BY GOVERNOR)**

AN ACT CONCERNING RECOMMENDATIONS OF THE SCHOOL NURSE ADVISORY COUNCIL

SUMMARY: This act generally requires each local or regional board of education to maintain a staffing ratio in its school district of at least one school nurse or nurse

practitioner for every 750 students. It allows a school nurse or nurse practitioner to provide services to more than one board as long as the minimum staffing ratio is met. By law, boards of education must appoint at least one school nurse or nurse practitioner for their education districts.

The act allows a local or regional board of education to annually request from the State Department of Education (SDE) commissioner a waiver from the staffing ratio requirement. The commissioner may approve the request for one year if he determines that maintaining the staffing ratio would have an adverse impact on students when balanced against the school district's other needs.

Additionally, the act requires each school nurse or nurse practitioner to complete the school nurse orientation program offered by SDE and the Association of School Nurses of Connecticut within one year of being hired, unless he or she already completed the program.

Under the act, school nurses and nurse practitioners must also meet the educational requirements specified in regulations adopted by the State Board of Education (SBE), in consultation with the Department of Public Health. Existing law already requires them to be qualified under SBE regulations.

EFFECTIVE DATE: July 1, 2016

Public Act 15-81—HB 6805

Signed by Governor

AN ACT CONCERNING THE BIRTH-TO-THREE PROGRAM AND HEARING TESTS

SUMMARY: This act establishes an October 1, 2015 deadline (the act's effective date) by which the Department of Developmental Services (DDS) commissioner must require, as part of the Birth-to-Three program, that notice of the availability of hearing tests be given to parents and guardians of children receiving program services who are exhibiting delayed speech, language, or hearing development.

The notice may include information on the benefits of, and available financial assistance for, hearing tests for children, as well as available hearing test and treatment resources.

The act allows the DDS commissioner to adopt implementing regulations.

PA 15-5, June Special Session, §§ 262 & 521, repeals this act. It establishes the same deadline and similar notice and regulatory provisions as the act, but it substitutes the Office of Early Childhood commissioner for the DDS commissioner and has an effective date of July 1, 2015.

The Birth-to-Three program is a private, provider-based system that provides services to families with infants and toddlers who have developmental delays or disabilities.

EFFECTIVE DATE: October 1, 2015

Public Act 15-198—HB 6856

Signed by Governor

AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION

SUMMARY: This act makes various changes affecting prescription drugs, drug abuse prevention, and related topics. It:

1. requires practitioners, before prescribing more than a 72-hour supply of a controlled substance, to check the patient's record in the prescription drug monitoring program;

2. requires practitioners to review the patient's record at least every 90 days if prescribing for prolonged treatment;

3. makes other changes to the prescription drug monitoring program, including exempting opioid agonists from its reporting requirements in certain situations;

4. allows pharmacists to prescribe opioid antagonists, used to treat drug overdoses, if they receive special training and certification to do so, and expands the existing immunity for all prescribers when prescribing, dispensing, or administering opioid antagonists;

5. requires physicians, advanced practice registered nurses (APRNs), dentists, and physician assistants (PAs) to take continuing education in pain management and prescribing controlled substances;

6. makes changes to membership and other matters concerning the Connecticut Alcohol and Drug Policy Council; and

7. adds pharmacists to the definition of "healing arts" in the health care center (HMO) statutes.

The act also makes technical and conforming changes.

EFFECTIVE DATE: Upon passage, except the provisions on the prescription drug monitoring program and continuing education are effective October 1, 2015.

§ 5 — ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

Requirements for Prescribers

Under the electronic prescription drug monitoring program, the Department of Consumer Protection (DCP) collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing.

Under the act, before prescribing more than a 72-hour supply of a controlled substance, the prescribing practitioner or his or her authorized agent must review the patient's records in the prescription drug monitoring program. (The agent must also be a licensed health care professional.) If the program is not operational, the prescriber may prescribe more than a 72-hour supply, as long as the prescriber or agent reviews the patient's records in the program within 24 hours after regaining access to the program. Additionally, the act requires the prescribing practitioner or agent to review a patient's

records in the program at least every 90 days when the practitioner prescribes controlled substances for continuous or prolonged treatment.

By law, various health care professionals are authorized to prescribe controlled substances, including physicians, APRNs, dentists, nurse-midwives, optometrists, PAs, podiatrists, and veterinarians.

Prescription Reporting

By law, pharmacists and other controlled substance dispensers must generally report certain prescription information to DCP under the program, such as the dispensing date, dispenser identification and prescription numbers, and patient identifying information.

Existing law requires the DCP commissioner to release the information, on written request, to a prescribing practitioner who is treating or has treated a specific patient, if the information is for treatment purposes (including drug monitoring). The act requires the commissioner to also release the information to such a practitioner's authorized agent who is also a licensed health care professional.

Prior law exempted from the program's reporting requirements institutional pharmacies or pharmacists' drug rooms operated by licensed institutions, when dispensing or administering opioid antagonists directly to patients to treat a substance use disorder. The act removes this exemption and instead applies the exemption to opioid agonists.

Opioid agonists are medications such as morphine that activate the same areas of the brain as other opioids. Opioid antagonists block the effect of opioids and are often used to treat drug overdoses (see below).

§§ 6 & 8 — OPIOID ANTAGONISTS

Prescriptive Authority for Pharmacists

Under certain conditions, the act allows licensed pharmacists to prescribe opioid antagonists. To do so, the pharmacist must (1) have been trained and certified by a program approved by the DCP commissioner and (2) act in good faith.

Under the act, a pharmacist who dispenses an opioid antagonist must train the recipient in how to administer it. The pharmacist must also maintain a record of the dispensing and training under the law's recordkeeping requirements. The act prohibits a pharmacist from delegating to or directing another person to prescribe an opioid antagonist or provide this training.

The act specifies that a pharmacist who prescribes an opioid antagonist and meets these requirements is not deemed to have violated any standard of care for pharmacists (see below for more on immunity from liability).

The DCP commissioner may adopt implementing regulations.

By law, an “opioid antagonist” is naloxone hydrochloride (e. g. , Narcan) or any other similarly acting and equally safe drug that the federal Food and Drug Administration has approved for treating a drug overdose.

Immunity from Liability

The act expands the civil and criminal immunity for licensed health care professionals authorized to prescribe an opioid antagonist, when prescribing, dispensing, or

administering it to treat or prevent a drug overdose. (The immunity applies to these actions or the subsequent use of the antagonist.) It does this by removing the condition that the immunity applies only if the professional acts with reasonable care.

The act also specifies that a professional who prescribes, dispenses, or administers an opioid antagonist in accordance with these provisions is deemed not to have violated the applicable standard of care. Finally, it makes a technical change to clarify that these professionals may prescribe, dispense, or administer the antagonist to anyone.

§§ 1-4 — CONTINUING EDUCATION

The act requires physicians, APRNs, dentists, and PAs to take continuing education in pain management and prescribing controlled substances, as follows.

For physicians, this applies as part of the existing requirement that they take at least one contact hour (i. e., at least 50 minutes of continuing education) of risk management training or education (1) during their first license renewal period in which continuing education is required and (2) at least once every six years after that. For APRNs, the act's requirement applies as part of the existing requirement that they take at least one contact hour of substance abuse training or education every two years. (Both physicians and APRNs generally must complete 50 hours of continuing education every two years, starting with their second license renewal.)

The act specifies that its requirement applies to physicians for registration periods beginning on or after October 1, 2015.

For dentists, the act requires at least one contact hour every two years of training or education in pain management and prescribing controlled substances. The act makes a corresponding change by providing that dentists' other continuing education must include at least one contact hour in any four, rather than five, of the 10 mandatory topics prescribed by the public health commissioner. (Dentists generally must complete 25 hours of continuing education every two years, starting with their second license renewal.)

For PAs, the act requires at least one contact hour every two years of training or education in pain management and prescribing controlled substances. (By law, to renew their licenses, PAs must have completed the mandatory continuing education requirements needed to maintain national certification.)

§ 9 — ALCOHOL AND DRUG POLICY COUNCIL

By law, the Connecticut Alcohol and Drug Policy Council is charged with (1) reviewing state policies on substance abuse treatment and prevention programs, as well as criminal sanctions and programs, and (2) developing and coordinating a statewide plan for these matters.

The act moves the council to the Department of Mental Health and Addiction Services (DMHAS). Previously, it was in the Office of Policy and Management (OPM) for administrative purposes only. It thus eliminates the requirement that OPM provide staff for the council within available appropriations.

The act also makes several changes in the council's membership. It adds the aging commissioner, chairperson of the Board of Regents for Higher Education, and UConn

president, or their designees. It removes the higher education, motor vehicles, and transportation commissioners and the chairperson of the board of pardons and paroles, or their designees. (The position of higher education commissioner was eliminated in 2011.)

The act also allows the council's co-chairpersons (the DMHAS and children and families commissioners) to jointly appoint up to seven members, including:

1. two people in recovery from a substance use disorder or who represent an advocacy group for people with these disorders,
2. a provider of community-based substance abuse services for adults,
3. a provider of these services for adolescents,
4. an addiction medicine physician,
5. a relative of someone in recovery, and
6. an emergency medicine physician currently practicing at a hospital in the state.

§ 7 — HEALING ARTS IN HMO STATUTES

The act adds pharmacists to the definition of "healing arts" in the HMO statutes. Various provisions in the HMO statutes refer to healing arts, including provisions on:

1. training provided under the direction of people licensed to practice a healing art (CGS §§ 38a-176 and -177),
2. required representation for healing arts practitioners on the boards of HMOs organized as nonprofit corporations (CGS § 38a-179), and
3. allowing (a) healing arts practitioners to be employed by and participate in HMOs and (b) patients to choose healing arts practitioners in the HMO (CGS § 38a-180).

Pharmacists are not included in the more general statutory definition of healing arts (CGS § 20-1).

Public Act 15-172—HB 6884

Signed by Governor

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING CHILDHOOD LEAD POISONING PREVENTION AND CONTROL

SUMMARY: This act lowers the blood lead level threshold at which local health directors must inform parents or guardians about (1) a child's potential eligibility for the state's Birth-to-Three program and (2) lead poisoning dangers, ways to reduce risks, and lead abatement laws.

Under existing law, local health directors must provide this information after receiving a report from a clinical laboratory or health care institution that a child has been tested with a blood lead level of at least 10 micrograms of lead per deciliter of blood (10 µg/dL) or any other abnormal body lead level. The act requires them to also provide this

information when a child is known to have a confirmed venous blood lead level of at least five µg/dL.

The act specifies that the local health director must provide the information to the parent or guardian only once, after the director receives the initial report.

EFFECTIVE DATE: October 1, 2015

Public Act 15-13—HB 6886

Signed by Governor

AN ACT CONCERNING THE APPLICABILITY OF GENETICALLY-ENGINEERED FOOD LABELING REQUIREMENTS TO NONALCOHOLIC MALT BEVERAGES

SUMMARY: This act exempts nonalcoholic malt beverages from the law's genetically engineered food labeling requirements. These beverages are those with up to . 5% alcohol by volume, obtained by alcohol fermentation of an infusion or concoction of water, hops, barley malt, or cereal grains.

By law, foods intended for human consumption that are entirely or partially genetically engineered must be labeled as such after four other states pass similar laws, provided one state borders Connecticut and the total population of these states in the northeast exceeds 20 million. (This threshold has not been reached.)

The law already exempts certain food products, such as (1) alcoholic beverages, (2) food not packaged for retail sale that is intended for immediate consumption, and (3) certain farm products.

EFFECTIVE DATE: July 1, 2015

Public Act 15-129—HB 6892

Signed by Governor

AN ACT CONCERNING HOSPITAL TRAINING AND PROCEDURES FOR PATIENTS WITH SUSPECTED DEMENTIA

SUMMARY: Starting October 1, 2015, this act requires hospitals to train direct care staff in the symptoms of dementia as part of their regular staff training.

In general, neither state law nor regulation specifies training requirements for hospital direct care staff. In practice, hospitals must comply with clinical training requirements set by certain regulatory and accrediting agencies, including the federal Occupational Safety and Health Administration and the Joint Commission (an independent, national accrediting agency for hospitals and health care organizations).

EFFECTIVE DATE: July 1, 2015

Public Act 15-130—HB 6894

Signed by Governor

AN ACT CONCERNING THE SAFEGUARDING OF FUNDS FOR RESIDENTS OF CERTAIN LONG-TERM CARE FACILITIES

SUMMARY: This act extends to residential care homes (RCHs) statutory requirements for nursing homes regarding the management of residents' personal funds. The requirements include notification and account management procedures and penalties for failure to comply.

Existing Department of Social Services (DSS) regulations establish similar procedures and requirements for managing RCH residents' personal funds. Presumably, RCHs would continue to follow these regulations in areas left unaddressed by the act (e. g., submitting to DSS annual statements on residents' accounts and accounting procedures when an RCH transfers ownership) (Conn. Agencies Reg., § 17-109a).

By law, an RCH is an establishment that (1) furnishes, in single or multiple facilities, food and shelter to at least two people unrelated to the proprietor and (2) provides services that meet a need beyond the basic provisions of food, shelter, and laundry (CGS § 19a-521).

The act also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2015

Public Act 15-163—HB 6937

Signed by Governor

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING THE DEFINITIONS OF SEDATION AND GENERAL ANESTHESIA

SUMMARY: This act updates the statutory definitions of sedation and general anesthesia related to dentistry to reflect industry standards by:

1. eliminating the definition of “conscious sedation” in the dentistry statutes and replacing it with new definitions for “minimal sedation,” “moderate sedation,” and “deep sedation;”

2. updating the definition of “general anesthesia;”

3. extending to dentists using moderate or deep sedation existing permitting requirements for the use of general anesthesia; and

4. exempting dentists using minimal sedation from these permitting requirements.

The act authorizes the state Dental Commission to take disciplinary action against a dentist permitted to use moderate or deep sedation who fails to successfully complete an on-site evaluation of his or her office. Among other things, this includes license revocation or suspension, censure, a letter of reprimand, or a civil penalty. (The commission may already take these actions against general anesthesia permit holders who fail to complete the evaluation.)

EFFECTIVE DATE: October 1, 2015

Public Act 15-174—HB 6949

Signed by Governor

AN ACT CONCERNING CHILDHOOD VACCINATIONS

SUMMARY: Existing law exempts children from school immunization requirements if the child presents a statement from his or her parents or guardians that the immunization would be contrary to the child's religious beliefs. This act additionally exempts children who present a statement that the immunization would be contrary to the parents' or guardians' religious beliefs. It requires any such statement to be officially acknowledged by a notary public, Connecticut-licensed attorney, judge, family support magistrate, court clerk or deputy clerk, town clerk, or justice of the peace. **(PA 15-242, HB 6987, Section 68 also allows school nurses to officially acknowledge the statement.)**

The act extends the above requirement to children (1) attending child day care centers and group or family day care homes and (2) whose parents or guardians object to such immunization on religious grounds. (Existing Office of Early Childhood regulations require the submission of a religious exemption statement, but do not require it to be acknowledged.)

Under the act, the child's parents or guardians must submit the religious exemption statement annually in order for the child to remain enrolled in a public or private school, child day care center, or group or family day care home. (PA 15-242 eliminates the annual submission requirement and instead requires submission of the statement (1) once for children attending child day care centers and group or family day care homes and (2) before a public or private school student enrolls in seventh grade, in addition to when he or she initially enrolls in school, as existing law requires.)

In addition to the above religious exemption, existing law also provides a medical exemption for children who document that such immunization is medically contraindicated.

The act also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2015

Special Act 15-17 - HB-6975

Signed by Governor

AN ACT ESTABLISHING A TASK FORCE TO STUDY LIFE-THREATENING FOOD ALLERGIES IN SCHOOLS.

Section 1. (***Effective from passage***) (a) There is established a task force to study life-threatening food allergies in schools. The task force shall examine (1) the efficacy of the implementation, dissemination and enforcement of the guidelines for the management of students with life-threatening food allergies and glycogen storage disease, developed by the Department of Education pursuant to section

10-212c of the general statutes, (2) methods used by school districts to ensure the safety of students with life-threatening food allergies while such students are being transported to and from school, (3) the plans for the management of students with life-threatening food allergies and glycogen storage disease, implemented by local and regional boards of education pursuant to section 10-212c of the general statutes, to ensure the safety of students with life-threatening food allergies and their inclusion as fully participating members in the school community, (4) the emotional and psychosocial welfare of students with life-threatening food allergies as it relates to and is influenced by such students' membership in the school community and how such students are included or excluded from participating in school events, and (5) how instances of isolation or targeting of students with life-threatening food allergies by other students, school staff or school policy are addressed by the school or district administration.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut Association of Boards of Education and one of whom shall be a physician who is an allergist;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a certified teacher in a public elementary school and one of whom shall be the parent or guardian of a student with a life-threatening food allergy enrolled in a public school in the state;

(3) One appointed by the majority leader of the House of Representatives, who shall be the principal of a public middle school in the state;

(4) One appointed by the majority leader of the Senate, who shall be a school nurse supervisor;

(5) One appointed by the minority leader of the House of Representatives, who shall be the parent or guardian of a student with a life-threatening food allergy enrolled in a public school in the state;

(6) One appointed by the minority leader of the Senate, who shall be a food service director or cafeteria supervisor employed by a local or regional board of education;

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

(8) The Commissioner of Education, or the commissioner's designee; and

(9) One person appointed by the Governor, who shall be a mental health professional with an expertise in school climate.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) 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 task force.

(g) Not later than January 1, 2016, the task force shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2016, whichever is later.

Approved July 2, 2015

Public Act 15-242—HB 6987

Signed by Governor

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES

SUMMARY: This act makes numerous substantive, minor, and technical changes to Department of Public Health (DPH)-related statutes and programs. These changes affect several health care professions and institutions, including acupuncturists, certified behavior analysts, clinical and environmental laboratories, certified dietician-nutritionists, emergency medical services providers, hairdressers and cosmeticians, hospitals, mandated elder abuse reporters, massage therapists, medical spas, nuclear medicine technologists, nurses, opticians, and physician assistants.

Please review the attached summary of Public Act 15-242, HB 6987. In particular, see sections 3 (Physician Assistant Orders), 6 (Nurses from other states), 19 (Medical Spas), 34 (Childhood Nutrition Task Force), 35 (Rare Disease Task Force) and 68&71 (Childhood Immunizations). If you would like more information on this bill, please let me know.

Public Act 15-215—HB 7023

Signed by Governor

Brown Rudnick, CNA and ASNC worked closely with the chairs and various members of the Legislature's Education Committee to ensure that the language for the hearing, vision and postural screenings (as recommended by the American Academy of Pediatrics) was included in the Education Statutes bill.

AN ACT CONCERNING VARIOUS REVISIONS AND ADDITIONS TO THE EDUCATION STATUTES

SUMMARY: This act makes numerous changes in the education statutes, including:

1. decreasing the number of required hearing, vision, and postural screenings for public school students and adding a parental notice requirement that applies when a student does not receive the screening (§ 4);

2. granting agricultural science and technology center ("ag-science center") internship providers civil liability immunity from students and their parents or guardians for student interns' personal injuries, unless the injuries are caused by the providers' gross or willful negligence (§ 10);

3. specifying that the required union representation on a school district's professional development and evaluation committee include at least one representative chosen by each of the teachers' and administrators' unions (§ 11);

4. requiring the Connecticut Technical High School System (CTHSS) board, rather than the State Board of Education (SBE), to (a) adopt its long-range plan and biennial report and (b) maintain a rolling capital improvements plan (§§ 14 & 15);

5. modifying the (a) minimum budget requirement, (b) calculation for net expenses, and (c) teacher tenure law requirements for newly formed regional school districts (§§ 19-21); and

6. creating a process and requirements for the selection and training of school employees who administer anti-epileptic medications to students (§ 22).

The act makes numerous other minor changes to the education statutes.

EFFECTIVE DATE: July 1, 2015, except for the provisions regarding (1) indemnity, (2) appointments to the administrator standards council, and (3) teacher tenure, which are effective upon passage.

§ 4 — VISION, HEARING, AND POSTURAL SCREENINGS

The act decreases the number of mandatory vision, hearing, and postural screenings for public school students. Table 1 lists the changes by screening and grade. Under the act, vision and hearing screenings are offered in the same five grammar school years.

Table 1: Vision, Hearing, and Postural Screenings

Screening	*Grades under Prior Law*	*Grades under the Act*
Vision	K-6, inclusive, & 9	K, 1, 3-5, inclusive
Hearing	K-3, inclusive, 5 & 8	K, 1, 3-5, inclusive
Postural	5 – 9, inclusive	Female students: 5 & 7 Male students: 8 or 9

By law, the school superintendent must provide written notice to the parents of any student found to have any impairment, disease, or defect of vision or hearing or evidence of a postural problem. The act also requires, in a case where a student does not receive a screening, the superintendent to provide the parents with a statement explaining why the screening did not take place.

Public Act 15-72—SB 193

Signed by Governor

AN ACT CONCERNING THE ADMINISTRATION OF HAIR FOLLICLE DRUG TESTING BY CLINICAL LABORATORIES

SUMMARY: This act requires a clinical laboratory to administer a hair follicle drug test if (1) the laboratory offers that test as a diagnostic testing service and **(2) the test is ordered by a licensed physician, physician assistant, or advanced practice registered nurse.**

EFFECTIVE DATE: October 1, 2015

Public Act 15-4—SB 257

Signed by Governor

AN ACT CONCERNING REPORTING OF PAYMENTS BY MANUFACTURERS TO INDEPENDENTLY-PRACTICING ADVANCED PRACTICE REGISTERED NURSES

SUMMARY: Legislation enacted in 2014 requires manufacturers of covered drugs, devices, biologicals, and medical supplies to report to the Department of Consumer Protection (DCP) on payments or other transfers of value they make to advanced practice registered nurses (APRNs) practicing in Connecticut (see BACKGROUND).

This act:

1. extends, by two years, the due date for the first report, from July 1, 2015 to July 1, 2017; reduces the reporting frequency from quarterly to annually; and specifies that the reports cover the previous calendar year;

2. limits the reporting requirement to payments made to independently practicing APRNs (i. e, those not practicing in collaboration with a physician) (see BACKGROUND);

3. requires (a) the Department of Public Health, by December 1 annually, to publish on its website a list of APRNs authorized to practice independently, and (b) manufacturers to use the list when determining whether they must report to DCP; and

4. excludes from the reporting requirement the same payments excluded under the federal law on reporting payments to physicians and teaching hospitals.

EFFECTIVE DATE: Upon passage

MANUFACTURER REPORTING REQUIREMENT FOR PAYMENTS TO APRNS

Exceptions to Reporting Requirement

Under existing law, the reporting requirement does not apply to transfers made indirectly to an APRN through a third party, for an activity or service in which the manufacturer is unaware of the APRN's identity.

The act further excludes payments excluded under the federal Physician Payments Sunshine Act, which requires these manufacturers to report on payments or transfers of value to physicians or teaching hospitals (42 USC § 1320a-7h(e)(10)).

Thus, the act excludes the following from the reporting requirement:

1. transfers valued at under $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the recipient by the manufacturer during the calendar year exceeds $100, adjusted for inflation after 2012 (the 2015 thresholds are $10. 21 and $102. 07);

2. product samples intended for patient use and not intended for sale;

3. educational material directly benefiting patients or intended for them;

4. loans of a device for a short-term trial period, up to 90 days, to allow the recipient to evaluate the device;

5. items or services provided under a contractual warranty, including device replacement, where the warranty terms are set forth in the purchase or lease agreement;

6. transfers made when the recipient is a patient and not acting in his or her professional capacity;

7. discounts, including rebates;

8. in-kind items used to provide charity care;

9. dividends or other profit distributions from, or ownership or investment interests in, a publicly traded security and mutual fund;

10. payments to manufacturers who offer self-insured plans, for health care to employees under the plan;

11. payments to recipients also licensed as non-medical professionals, solely for those other professional services; and

12. payments solely for the recipient's services with respect to a civil or criminal action or an administrative proceeding.

BACKGROUND

Reporting of Manufacturer Payments to APRNs

By law, the reporting requirement applies to manufacturers of drugs, devices, biological products, or medical supplies covered by (1) Medicare or (2) the state Medicaid or Children's Health Insurance Program plan, including a plan waiver. These manufacturers must report the same information required by the federal Physician Payments Sunshine Act. Among other things, the reports must include the (1) recipient's name and business address, (2) amount and date of the payment or other transfer of value, and (3) form and nature of the payment or transfer.

A manufacturer that fails to report, as required, is subject to a civil penalty of $1,000 to $4,000 for each unreported payment or transfer.

Independently-Practicing APRNs

As of July 1, 2014, the law allows APRNs to practice independently if they have been (1) licensed and (2) practicing in collaboration with a physician for at least three years and 2,000 hours. After meeting these conditions, APRNs seeking to practice independently must notify the public health commissioner of their intention to do so.

Public Act 15-39—SB 258

Signed by Governor

AN ACT CONCERNING INFANT SAFE SLEEP PRACTICES

SUMMARY: This act requires hospitals, through their maternity programs, to provide newborn infants' parents or legal guardians with written information on the American Academy of Pediatrics' recommendations for safe sleep practices when the infants are discharged.

EFFECTIVE DATE: October 1, 2015

Public Act 15-32—SB 290

Signed by Governor

AN ACT CONCERNING PATIENT-DESIGNATED CAREGIVERS

SUMMARY: This act requires a hospital, when discharging a patient to his or her home, to:

1. allow the patient to designate a caregiver at or before the time the patient receives a written copy of his or her discharge plan;

2. document the designated caregiver in the patient's discharge plan;

3. attempt to notify the designated caregiver of the patient's discharge; and

4. instruct the caregiver on post-discharge tasks with which he or she will assist the patient at home.

The act specifies that it does not create a private right of action against a hospital or its employees, contractors, or consultants. It prohibits these entities and people from being held liable for services a caregiver provides or fails to provide to the patient in his or her home.

Additionally, the act does not affect (1) health insurers' benefit plan or reimbursement obligations, (2) a patient's discharge or transfer from a hospital to another facility, or (3) a patient's proxy health care rights.

By law, a "hospital" is an establishment that provides lodging, care, and treatment for people suffering from disease or other abnormal physical or mental conditions and includes general hospitals' inpatient psychiatric services.

EFFECTIVE DATE: October 1, 2015

DESIGNATED CAREGIVERS

Under the act, a "caregiver" is a person the patient designates to provide post-discharge assistance in the patient's home (e. g. , a relative, spouse, neighbor, or friend). A patient's home does not include a long-term facility (e. g. , a nursing home or assisted living facility), rehabilitation facility, hospital, or group home.

Post-discharge assistance includes help with basic and instrumental activities of daily living and support tasks (e. g. , wound care, medication administration, and medical equipment use) in accordance with the patient's written discharge plan signed by the patient or his or her representative.

The act prohibits a caregiver from receiving compensation for providing such assistance, including reimbursement from a private or public health insurer.

It does not require a patient to designate a caregiver nor does it obligate the caregiver to perform any post-discharge assistance for the patient.

DOCUMENTATION AND NOTIFICATION REQUIREMENTS

If an inpatient designates a caregiver before receiving his or her written discharge instructions, the act requires the hospital to:

1. record in the patient's discharge plan the caregiver's name, address, telephone number, and relationship to the patient and

2. make reasonable attempts to notify the caregiver of the patient's discharge as soon as practical.

The act specifies that the hospital's inability to contact the designated caregiver must not interfere with, delay, or otherwise affect the patient's medical care or appropriate discharge.

CAREGIVER INSTRUCTION

Requirements

The act requires hospitals, before discharging a patient, to provide the designated caregiver with instructions in all post-discharge assistance tasks included in the patient's discharge plan.

Caregiver training or instruction may be conducted in person or using video technology and must, to the extent possible, use nontechnical language. The act requires hospitals to determine which format will effectively provide the training but does not specify where the training must take place. At a minimum, it must include:

1. a live or recorded demonstration of the post-discharge assistance tasks performed by a hospital designee authorized to perform the tasks,

2. an opportunity for the caregiver to ask questions about the tasks, and

3. answers to the caregiver's questions.

The demonstration must be conducted in a culturally competent manner according to the hospital's requirements for providing language access services under state and federal law.

Documentation

The act requires hospitals to document in the patient's medical record any training provided to the patient, his or her representative, or the designated caregiver on how to implement the discharge plan.

The hospital must also document in the patient's medical record any caregiver instruction provided on post-discharge assistance tasks, including the date, time, and content of such instruction.

HEALTH INSURER OBLIGATIONS

The act specifies that its provisions must not be construed to:

1. eliminate the obligation of an insurance company; health, hospital, or medical service corporation; HMO; or any other entity issuing health benefit plans to provide required benefit coverage or

2. impact, impede, or otherwise disrupt or reduce these entities' reimbursement obligations.

PATIENTS' PROXY HEALTH RIGHTS

The act specifies that its provisions do not affect or take precedence over an advance directive, conservatorship, or other proxy health care rights the patient delegates or applies by law.

Public Act 15-6—SB 426

Signed by Governor

AN ACT CONCERNING EMPLOYEE ONLINE PRIVACY

SUMMARY: This act generally prohibits employers from requesting or requiring an employee or job applicant to (1) provide the employer with a user name, password, or other way to access the employee's or applicant's personal online account (see below); (2)

authenticate or access such an account in front of the employer; or (3) invite, or accept an invitation from, the employer to join a group affiliated with such an account.

It bars employers from:

1. firing, disciplining, or otherwise retaliating against an employee who (a) refuses to provide this access or (b) files a complaint with a public or private body or court about the employer's request for access or retaliation for refusing such access or

2. refusing to hire an applicant because the applicant would not provide access to his or her personal online account.

Under the act, a "personal online account" is an online account the employee or applicant uses exclusively for personal purposes unrelated to any of the employer's business purposes, including e-mail, social media, and retail-based Internet web sites. It does not include any account created, maintained, used, or accessed by an employee or applicant for the employer's business purposes.

The act provides exceptions for accounts and devices the employer provides and certain types of investigations. Covered employers include the state and its political subdivisions, but the act does not apply to a state or local law enforcement agency conducting a preemployment investigation of law enforcement personnel.

The act allows employees and applicants to file a complaint with the labor commissioner, who can impose civil penalties on employers of up to $25 for initial violations against job applicants and $500 for initial violations against employees. Penalties for subsequent violations can be up to $500 for violations against applicants and up to $1,000 for violations against employees.

EFFECTIVE DATE: October 1, 2015

Public Act 15-88—SB 467

Signed by Governor

AN ACT CONCERNING THE FACILITATION OF TELEHEALTH

SUMMARY: This act establishes requirements for health care providers who provide medical services through the use of "telehealth" as defined below. Among other things, a telehealth provider must obtain a patient's informed consent, at the first telehealth interaction, to provide telehealth services.

The act also requires certain health insurance policies to cover medical services provided through telehealth to the extent that they cover the services through in-person visits between an insured person and a health care provider.

EFFECTIVE DATE: October 1, 2015, except for the insurance coverage provisions, this is effective January 1, 2016.

TELEHEALTH PROVIDER REQUIREMENTS

Definitions

The act defines a "telehealth provider" as any of the following who provides health care services through the use of telehealth within his or her scope of practice and in

accordance with the profession's standard of care: a licensed physician, advanced practice registered nurse, physician assistant, occupational or physical therapist, naturopath, chiropractor, optometrist, podiatrist, psychologist, marital and family therapist, clinical or master social worker, alcohol and drug counselor, professional counselor, or certified dietitian-nutritionist.

It defines "telehealth" as delivering health care services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's physical and mental health. It includes:

1. interaction between a patient at an originating site and the telehealth provider at a distant site and

2. synchronous (real-time) interactions, asynchronous store and forward transfers (transmitting medical information from the patient to the telehealth provider for review at a later time), or remote patient monitoring.

Telehealth does not include using fax, audio-only telephone, texting, or e-mail.

Requirements

Under the act, a telehealth provider can provide telehealth services to a patient only when the provider:

1. is communicating through real time, interactive, two-way communication technology or store and forward technologies;

2. has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the patient's primary care provider's name and address, if any;

3. gives the patient his or her provider license number and contact information; and

4. conforms to the standard of care for his or her profession and expected for in-person care as appropriate for the patient's age and presenting condition. But when the standard of care requires the use of diagnostic testing and a physical examination, the provider may perform the testing or examination though appropriate peripheral devices (i. e. , instruments he or she uses to examine a patient).

The act requires a telehealth provider, at his or her first telehealth interaction with a patient, to (1) inform the patient about the treatment methods and limitations of treating a person through telehealth and (2) obtain the patient's consent to provide telehealth services. The provider must document the notice and consent in the patient's health record.

Prohibitions

The act prohibits a telehealth provider from (1) prescribing schedule I, II, or III controlled substances through the use of telehealth or (2) charging a facility fee for telehealth services.

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and

distinct from a professional fee, which is a fee charged or billed by a provider for professional medical services provided in a hospital-based facility.

Records and HIPAA Compliance

The act requires a telehealth provider, at each telehealth interaction with a patient, to obtain the patient's consent to provide records of the interaction to his or her primary care provider. If the patient consents, the records must be provided in a timely manner and in accordance with the standard access to health records law. Providers must maintain and disclose records of telehealth interactions and provide telehealth services in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA).

Allowable Transactions

The act allows a licensed or certified health care provider to (1) provide on-call coverage for another provider, (2) consult with another provider about a patient's care, or (3) issue orders for hospital patients.

INSURANCE COVERAGE REQUIREMENTS

Coverage Required

The act requires certain health insurance policies to cover medical advice, diagnosis, care, or treatment provided through telehealth to the extent that they cover those services through in-person visits between an insured person and a health care provider. It subjects telehealth coverage to the same terms and conditions that apply to other benefits under the policy.

Under the act, insurers and related entities (e. g. , HMOs) may conduct utilization review for telehealth services in the same manner it is conducted for in-person services, including using the same clinical review criteria.

Prohibitions

The act prohibits health insurance policies from:

1. excluding coverage solely because a service is provided through telehealth, provided telehealth is appropriate for the service or

2. having to reimburse a treating or consulting health care provider for any technical fees or costs associated with providing telehealth services.

Applicability

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage provided to subscribers of a health care center (i. e. , HMO). Under the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

Public Act 15-15—SB 850

Signed by Governor

AN ACT AMENDING THE CODE OF ETHICS FOR LOBBYISTS TO REDEFINE "EXPENDITURE" AND RAISE THE THRESHOLD FOR LOBBYIST REGISTRATION

SUMMARY: This act increases, from $2,000 to $3,000, the income and expenditure thresholds requiring a person to register as a lobbyist with the Office of State Ethics (OSE). It requires a person to register with OSE if he or she, in a calendar year, receives, spends, or agrees to receive or spend at least $3,000, rather than $2,000, to lobby. Similarly, the act requires registered lobbyists that are (1) associations, groups, or organizations and (2) formed primarily for lobbying to include with their biennial registration the names and addresses of everyone who contributes at least $3,000, rather than $2,000, to their lobbying activities in any calendar year.

The act exempts from the definition of a lobbying "expenditure" the costs to an entity for transporting its members, shareholders, or employees to or from a specific site, as long as these individuals received no other compensation or reimbursement for lobbying. It also specifies that existing law's expenditure exemption for an entity's publication of a newsletter or other release to its members, shareholders, or employees (1) must be intended primarily for these individuals (prior law referred only to communications made to these individuals) and (2) applies whether the communication is in paper or electronic form or made orally during a regularly noticed meeting.

EFFECTIVE DATE: January 1, 2016

Public Act 15-91—SB 855

Signed by Governor

AN ACT CONCERNING REPORTS OF NURSE STAFFING LEVELS

SUMMARY: This act requires hospitals to report annually to the Department of Public Health (DPH) on their prospective nurse staffing plans, rather than make the plans available to DPH upon request as prior law required. It expands, in two stages, the information that must be included in the plans, such as the (1) ratio of patients to certain nursing staff and (2) differences between the prospective staffing levels and actual levels.

The act requires the DPH commissioner to annually report, beginning by January 1, 2016, to the Public Health Committee on hospital compliance with nurse staffing plan reporting requirements and recommendations for any additional reporting requirements.

The act also requires certain health care employers to report to DPH annually, rather than upon the department's request, on the number of workplace violence incidents occurring on the employer's premises and the specific area or department where they occurred. The first report is due by January 1, 2016, and the reports must cover incidents occurring in the prior year.

For this purpose, a "health care employer" is any DPH-licensed institution (e. g. , a hospital or nursing home) with at least 50 full- or part-time employees. It includes (1)

facilities that care for or treat people with substance abuse issues or mental illness; (2) Department of Developmental Services-licensed residential facilities for people with intellectual disability, and (3) community health centers.

EFFECTIVE DATE: July 1, 2015, except the workplace violence provisions are effective October 1, 2015.

PROSPECTIVE NURSE STAFFING PLANS

In addition to the information already required by law, the act requires hospital nurse staffing plans developed and implemented after January 1, 2016 to include:

1. the number of direct patient care staff in three categories (registered nurses, licensed practical nurses, and assistive personnel) and the ratio of patients to each category, reported by patient care units;

2. the hospital's method for determining and adjusting direct patient care staffing levels; and

3. a description of supporting personnel assisting on each patient care unit.

Under the act, plans developed and implemented after January 1, 2017 also must include (1) a description of any differences between the plan's staffing levels and actual staffing levels for each patient care unit and (2) the hospital's intended actions, if any, to address these differences or adjust staffing levels in future plans.

Public Act 15-86—SB 914

Signed by Governor

AN ACT CONCERNING AN EMPLOYER'S FAILURE TO PAY WAGES

SUMMARY: With one exception, this act requires, rather than allows, a court to award double damages plus court costs and attorney's fees if it finds that an employer failed to (1) pay an employee's wages, accrued fringe benefits, or arbitration award or (2) meet the law's requirements for an employee's minimum wage or overtime rates.

Under the act, the double-damage requirement does not apply to employers who show they had a good-faith belief that their underpayments were legal. Such employers must, however, pay the full amount of the wages (less any amount they already paid) plus court costs and attorney's fees. By law, the labor commissioner can collect unpaid wages and payments or bring a civil suit on the employee's behalf.

EFFECTIVE DATE: October 1, 2015

Public Act 15-59—SB 917

Signed by Governor

AN ACT CONCERNING SCHOOL-BASED HEALTH CENTERS

SUMMARY: This act establishes a statutory definition for a "school-based health center" (SBHC) and permits the Department of Public Health (DPH) to adopt regulations to establish minimum quality standards for these centers. Under the act, an SBHC:

1. is located in or on the grounds of a school facility of a school district, school board, Indian tribe, or tribal organization;

2. is organized through school, community, and health provider relationships;

3. is administered by a sponsoring facility (e. g. , hospital, health department, community health center, or nonprofit health or human services agency); and

4. provides comprehensive on-site medical and behavioral health services to children and adolescents according to state and local law.

The act prohibits anyone from using the term SBHC to describe a facility or any words or abbreviations that may be reasonably confused with this term, unless the facility meets the act's definition.

Additionally, the act establishes a statutory definition for an "expanded school health site" and extends to these sites certain statutory provisions regarding SBHCs. Among other things, this means the (1) sites may receive DPH grants for community-based primary care providers, (2) SBHC Advisory Council must advise the DPH commissioner on matters related to the sites, and (3) sites are exempt from DPH's certificate of need requirements.

Under the act, an "expanded school health site" is defined the same way as an SBHC, except that the (1) term does not include health centers located in or on the grounds of an Indian tribe or tribal organization and (2) sites provide either medical or behavioral services, including dental services, counseling, health education, and screening and prevention services.

EFFECTIVE DATE: October 1, 2015

Public Act 15-112—SB 926 (**VETOED BY GOVERNOR)**

AN ACT CONCERNING UNSUBSTANTIATED ALLEGATIONS OF ABUSE OR NEGLECT BY SCHOOL EMPLOYEES

SUMMARY: This act requires the (1) Department of Children and Families (DCF) to notify certain education officials when it cannot substantiate a report that a school employee abused or neglected a child and (2) education officials to remove references to the report and DCF investigation from the employee's personnel records and any other records relating to him or her. It prohibits using such an unsubstantiated report against the employee for any employment-related purpose.

EFFECTIVE DATE: July 1, 2015

UNSUBSTANTIATED REPORTS OF ABUSE AND NEGLECT

Notification and Removal from Records

The law requires DCF to take certain actions when it receives a report that a school employee abused or neglected a child, including investigating the report and notifying the education commissioner and employing superintendent of its findings within five working days after the investigation ends. The act requires DCF to also notify the school employee within this time period.

The act also requires DCF to notify the employee, education commissioner, employing superintendent, and employing school or school district if it cannot substantiate such a report. On receiving this information, the State Department of Education, employing superintendent, and employing school or school district must remove any reference to the report and investigation from the employee's personnel records and any other records relating to him or her. The act does not set specific deadlines for DCF to notify the education officials and for the education officials to remove the records, but these actions must apparently take place immediately on completing the investigation and on receiving the notice from DCF, respectively.

Prohibitions on Use of Unsubstantiated Report

Under the act, an unsubstantiated report of abuse or neglect cannot be used against the employee for any employment-related purpose. These include matters of discipline, salary, promotion, transfer, demotion, retaining or continuing employment, termination, or any employment-related right or privilege.

BACKGROUND

School Employee

By law, a school employee is:

1. a teacher, substitute teacher, school administrator, school superintendent, guidance counselor, psychologist, social worker, nurse, physician, school paraprofessional, or coach (a) employed by a local or regional board of education or a private elementary, middle, or high school or (b) working in a public or private elementary, middle, or high school or

2. any other person who, in the performance of his or her duties, has regular contact with students and who provides services to or on behalf of students enrolled in (a) a public elementary, middle, or high school, under a contract with the local or regional board of education, or (b) a private elementary, middle, or high school, under a contract with the supervisory agent of the private school (CGS § 53a-65).

Public Act 15-16—SB 966

Signed by Governor

AN ACT CONCERNING SEXUAL ASSAULT FORENSIC EXAMINERS AT INSTITUTIONS OF HIGHER EDUCATION

SUMMARY: This act allows sexual assault forensic examiners (SAFE) to treat sexual assault victims who are patients in a health care facility operated by a higher education institution. SAFEs may treat these patients if the health care facility is (1) licensed by the Department of Public Health (DPH) as an infirmary operated by an educational

institution or as an outpatient clinic and (2) accredited by the Joint Commission or the Accreditation Association for Ambulatory Health Care (see BACKGROUND). Prior law allowed SAFEs to treat only acute care hospital patients.

The act also allows SAFEs working in higher education health care facilities, like SAFEs in acute care hospitals, to collect evidence pertaining to the investigation of any sexual assault using the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault (see BACKGROUND).

The act requires that SAFE services provided in a higher education health care facility, as they are under existing law in acute care hospitals, be (1) aligned with the facility's policies and accreditation and (2) pursuant to a written agreement between the health care facility and (a) DPH and (b) the Office of Victim Services, about the facility's participation in the SAFE program.

These provisions do not alter the scope of the practice of nursing established in state law.

EFFECTIVE DATE: July 1, 2015

BACKGROUND

Sexual Assault Forensic Examiners (SAFE)

SAFEs are state-licensed (1) registered nurses, (2) advanced practice registered nurses, or (3) physicians (CGS § 19a-112g).

Joint Commission

The Joint Commission is an independent, nonprofit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States.

Technical Guidelines for Health Care Response to Victims of Sexual Assault

The state's Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations publishes these guidelines (CGS § 19a-112a).

Public Act 15-47—SB 988

Signed by Governor

AN ACT UPDATING THE OCCUPATIONAL HEALTH CLINICS STATUTES

SUMMARY: This act authorizes the labor commissioner, when awarding grants for occupational health clinics, to give priority to certain organizations providing services for working-age populations, including migrant and contingent workers. She must give priority to these clinics where work structures or workers' health disparities interfere with providing occupational health care services. Under the act, “contingent worker” means a person whose employment is temporary and sporadic and may include agricultural workers, independent contractors, or day or temporary workers. Under the act, an independent contractor means someone who is not an employee and whose compensation must be reported on an IRS Form 1099.

By law, the commissioner may award grants to occupational health clinics operated by public and nonprofit organizations.

The act also makes (1) minor changes to grant usage and to some definitions under the occupational health clinic law and (2) technical changes.

EFFECTIVE DATE: October 1, 2015

Public Act 15-49—SB 998

Signed by Governor

AN ACT CONCERNING PRESCRIPTION DRUGS

SUMMARY: This act expands prohibitions concerning counterfeit drugs and devices to include knowingly dispensing, importing, or reimporting into the state such drugs or devices. The law already prohibits knowingly purchasing for resale, selling, offering for sale, or delivering these items.

By law, a “counterfeit drug or device” is a drug or device, or its container or label that, without authorization, (1) bears the trademark, trade name, or other identifying mark, imprint, number, or device (or their likenesses), of a manufacturer, distributor, or dispenser other than the person who manufactured, distributed, or dispensed the substance and (2) falsely claims or represents that the drug or substance was distributed by the other manufacturer, distributor, or dispenser.

The act subjects violators to both criminal and civil penalties, including, for each violation, a maximum (1) criminal fine of $10,000, one year imprisonment, or both, or (2) civil fine of $1,000. It also allows the Department of Consumer Protection (DCP) commissioner to investigate and take various disciplinary actions (see BACKGROUND).

The act also provides that any prescribing practitioner who takes any of the act's or the law's prohibited actions is subject to certain Department of Public Health (DPH) disciplinary actions, including a maximum civil fine of $25,000 (see BACKGROUND).

EFFECTIVE DATE: October 1, 2015

BACKGROUND

Disciplinary Actions

DCP. By law, the DCP commissioner can take the following actions, among others, against anyone who knowingly violates the counterfeit drug or device law:

1. suspend, revoke, refuse to renew, or place on probation a DCP license or registration;

2. issue a cease and desist order; or

3. issue a restitution order (CGS § 21a-90).

DPH. By law, DPH can take the following disciplinary actions, among others:

1. suspend or revoke the person's DPH license or permit,

2. issue a letter of reprimand to or censure the person,

3. place him or her on probation, or

4. take summary action against the person's DPH license or permit if he or she has been found guilty of a state or federal felony or is subject to disciplinary action in another jurisdiction (CGS § 19a-17).

Public Act 15-223—SB 999

Signed by Governor

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING EMERGENCY MEDICAL SERVICES

SUMMARY: This act makes various changes in the emergency medical services (EMS) laws, including emergency scene responsibilities, data reporting requirements, and credentialing. Among other things, the act:

1. establishes a hierarchy for determining which EMS provider is responsible for making patient care decisions at the scene of an emergency call, giving decision-making authority to the provider holding the highest classification of licensure or certification;

2. specifies that these provisions do not limit the authority of the fire officer-in-charge to control and direct emergency activities at the scene;

3. establishes a civil penalty of up to $100 per day for an EMS organization's failure to report data as required, in addition to existing penalties;

4. allows the Department of Public Health (DPH) commissioner to adopt regulations on the EMS data collection system; and

5. specifies certain exemptions from EMS provider certification, extending an existing exemption from paramedic licensure.

The act also makes many minor, technical, and conforming changes.

EFFECTIVE DATE: October 1, 2015

Public Act 15-226—SB 1085

Signed by Governor

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS

SUMMARY: This act specifies the services certain health insurance policies must cover for mental and nervous conditions. By law, a policy must cover the diagnosis and treatment of mental or nervous conditions on the same basis as medical, surgical, or other physical conditions (i. e. parity).

The act requires policies to at least cover, among other things:

1. medically necessary acute treatment and clinical stabilization services;

2. general inpatient hospitalization, including at state-operated facilities; and

3. programs to improve health outcomes for mothers, children, and families.

Under the act, a policy may not prohibit an insured from receiving, or a provider from being reimbursed for, multiple screening services as part of a single-day visit to a health care provider or multicare institution (e. g. , hospital, psychiatric outpatient clinic, or free standing facility for substance use treatment).

The act substitutes the term “benefits payable” for “covered expenses” pertaining to the mental or nervous condition coverage provisions. By law, these are the usual, customary, and reasonable charges for medically necessary treatment or, in the case of a managed care plan, the contracted rates.

The act also requires the insurance commissioner and healthcare advocate to convene a working group to study, among other things, the use of inpatient mental health and substance use disorder services. (PA 15-5, June Special Session, § 515 repeals this requirement.)

The act applies to individual and group health insurance policies issued, delivered, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO. Due to the federal Employee Retirement Income Security Act, state insurance mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016, except for the working group provisions, which are effective on passage.

BUDGET BILL - Public Act 15-244

Signed by Governor

HB 7061 (as amended by House "A")*

AN ACT CONCERNING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017, AND MAKING APPROPRIATIONS THEREFOR, AND OTHER PROVISIONS RELATED TO REVENUE, DEFICIENCY APPROPRIATIONS AND TAX FAIRNESS AND ECONOMIC DEVELOPMENT.

SUMMARY: This bill appropriates funds for state agencies and programs for FY 16 and FY 17. It also makes various state tax and revenue changes.

Please see budget sections of interest to CNA below:

§§ 112-137 — DPH LICENSE RENEWAL FEES

The bill (1) increases by $5 license renewal fees for various DPH-licensed professionals, and (2) directs the revenue generated to fund the professional assistance program for DPH-regulated professionals (currently, the Health Assistance InterVention Education Network (HAVEN)). By law, the program is an alternative, voluntary, and confidential rehabilitation program that provides support services to health professionals with a chemical dependency, emotional or behavioral disorder, or physical or mental illness.

The DPH commissioner must (1) certify the amount of revenue received as a result of the fee increase each January, April, July, and October (2) transfer it to the professional assistance program account, which the bill establishes, and (3) provide the funds to the to the professional assistance program.

EFFECTIVE DATE: July 1, 2015

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§ 172 — AMBULATORY SURGICAL CENTER TAX

The bill imposes a 6% gross receipts tax on Department of Public Health-licensed and Medicare-certified ambulatory surgical centers. These centers perform surgery and related services on patients that take less than a day and do not require hospitalization. The centers must remit the tax quarterly, beginning with the last quarter calendar of 2015. The tax is due on the last day of the month preceding the quarter. When it does so, it must file the return electronically and remit the tax by electronic funds transfer. The return must identify the center's name and location and provide any other information the Department of Revenue Services commissioner requires.

Centers that fail to remit the tax face a 10% penalty or $50, whichever is greater, plus interest at 1% per month. The bill gives the commissioner the same statutory enforcement powers he has under the law to enforce admission and dues taxes.

The bill authorizes the comptroller to record the revenue the tax generates each fiscal year no later than five business days after the end to the fiscal year.

EFFECTIVE DATE: October 1, 2015

BUDGET IMPLEMENTER BILL

June 2015 Special Session, Public Act 15-5

Signed by Governor

SB 1502

AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017 CONCERNING GENERAL GOVERNMENT, EDUCATION AND HEALTH AND HUMAN SERVICES.

SUMMARY: Please see sections below of interest to CNA.

EFFECTIVE DATE: Various, see below

§ 50 — MICROBEADS

The bill phases in bans on manufacturing for sale, importing, selling, or offering for sale personal care products and over-the-counter drugs with intentionally added synthetic solid plastic particles of five millimeters or less in size that are (1) used to exfoliate or cleanse and (2) intended to be rinsed or washed off the body and deposited into a sink, shower, or bathtub drain (i.e., microbeads).

The bill applies to:

1. products, or their components, intended for rubbing, pouring, sprinkling, spraying on, introducing into, or applying to the human body for cleansing, beautifying, promoting attractiveness, or altering its appearance ("personal care products") and

2. personal care products with labels required by federal regulation identifying them as drugs ("over-the-counter drugs").

It excludes products the Department of Consumer Protection (DCP) commissioner determines need a prescription to distribute or dispense.

Phased-in Bans

Personal care products. The bill prohibits, beginning December 31, 2017, manufacturing for sale in Connecticut personal care products with microbeads. And, starting December 31, 2018, it bans importing, selling, or offering them for sale.

But if the microbead study described below is not completed by its due date of December 15, 2017, the bans both take effect on July 1, 2018.

Over-the-counter drugs. Beginning December 31, 2018, the bill prohibits manufacturing for sale in Connecticut over-the-counter drugs with microbeads. And beginning December 31, 2019, it prohibits importing, selling, or offering them for sale.

Regulations

The bill allows the DEEP commissioner to adopt regulations, in consultation with the DCP commissioner, to implement the bill's provisions.

Penalties

Violators of the bans or related DEEP regulations are subject to fines of up to (1) $5,000 for a first violation and (2) $10,000 for subsequent violations.

Biodegradable Microbeads Study

By August 15, 2016, the DEEP commissioner must accept an application on behalf of a personal care product manufacturer, for a study, at the commissioner's request, by the Connecticut Academy of Science and Engineering (CASE). The study must determine whether a biodegradable microbead is available to use in personal care products that does not adversely impact the environment or publicly owned treatment works in the state.

Under the bill, the application must (1) require the microbead manufacturer to disclose the biodegradable microbead's chemical parts or composition and (2) be in a form the commissioner prescribes.

The bill requires the commissioner to ask CASE to perform the study once he receives the application. CASE may establish a fee for doing so, which the manufacturer must pay through DEEP.

After receiving the request and fee from the commissioner, CASE must begin the study, which must include:

1. a CASE-appointed study committee to oversee it;

2. use of a CASE-selected research team with biodegradable microbead expertise to conduct relevant research and author the study report; and

3. study committee meetings that allow the applicant, DEEP, and interested people to obtain information about the study.

Under the bill, CASE must complete the study and issue a final study report to the commissioner by December 15, 2017. The commissioner must review the final report and forward it, and any of CASE's legislative recommendations, to the Environment Committee by February 1, 2018.

The bill exempts from disclosure under the Freedom of Information Act, any study related-information or materials submitted by an applicant to DEEP or CASE that the applicant indicates is a trade secret or privileged at the time of submission.

EFFECTIVE DATE: Upon passage

§§ 114-115 — CONCUSSION INFORMATION FOR YOUTH ATHLETES

The bill requires youth athletic activity operators, beginning by January 1, 2016, to annually make a written or electronic statement on concussions available to every youth participating in a youth athletic activity and his or her parent or legal guardian.

The operator must make the statement available when the youth registers. The statement must be consistent with current information provided by the National Centers for Disease Control and Prevention (CDC) on concussions and include information on:

1. concussion signs or symptom recognition,

2. how to obtain proper medical treatment for someone suspected of sustaining a concussion,

3. the nature of concussions and their risks, including the danger of continuing to engage in athletic activity after sustaining a concussion, and

4. proper procedures for allowing the athlete who sustained a concussion to return to athletic activity.

Under the bill, no operator or operator's designee is subject to civil liability for failing to make the written or electronic statement regarding concussions available, as required by the bill.

The bill also makes a technical change.

EFFECTIVE DATE: July 1, 2015

§ 131 — AMBULATORY SURGICAL CENTER TAX

PA 15-244 imposes a 6% gross receipts tax on Department of Public Health-licensed and Medicare-certified ambulatory surgical centers. The bill excludes from this tax any portion of a center's gross receipts that constitutes net patient revenue of a hospital that is subject to the hospital tax. It also allows the centers to seek remuneration for the 6% tax.

EFFECTIVE DATE: October 1, 2016

§§ 207 & 208 — MOTOR VEHICLE OPERATOR'S LICENSE MEDICAL ADVISORY BOARD

By law, the Motor Vehicle Operator's License Medical Advisory Board advises the DMV commissioner on the medical aspects and concerns of licensing motor vehicle operators. **The bill allows physicians assistants (PAs) and advanced practice registered nurses (APRNs) to (1) serve on the board and (2) complete physicals and medical reports requested by the board for the purposes of licensing decisions.** Under current law, only physicians and optometrists may perform these functions. The bill also allows such physicals and medical reports to be completed by medical professional licensed outside of Connecticut.

Under current law, the Connecticut State Medical Society and the Connecticut Association of Optometrists submit nominees from the specialties the law requires to serve on the board, and the commissioner selects board members from the nominees. Under the bill, professional medical associations that have PA or APRN members may also make such recommendations. The bill also adds occupational medicine to the list of specialties required on the board. Under the bill, the board must meet at least annually, instead of at least twice a year.

EFFECTIVE DATE: Upon passage

§§ 224 & 225 — MEDICAL PERMITS FOR PEOPLE WITH SUSPENDED LICENSES

Existing law allows certain people whose licenses have been suspended to apply for special “work” or “education” permits that allow them to drive to and from work or higher education institutions or private occupational schools. Under the bill, individuals may also apply for “medical” permits that allow them to drive to and from ongoing, medically necessary treatment. Individuals may not apply for this permit until DMV adopts regulations specifying the qualifications needed to obtain the permit. It also makes a conforming change.

EFFECTIVE DATE: Upon passage

§§ 262-264 – BIRTH TO THREE PROGRAM LEAD AGENCY

The bill makes OEC and its commissioner the lead agency for the Birth-to-Three program, which provides early intervention services to families with infants and toddlers who have developmental delays or disabilities.

It also requires the OEC commissioner to post notice of intention to adopt or amend regulations governing the collection of fees from early intervention service recipients on the eRegulations system, rather than print the notice in the Connecticut Law Journal. Additionally, it makes several conforming changes.

EFFECTIVE DATE: July 1, 2015

§§ 265 & 530 — BIRTH -TO-THREE HEARING TESTS

The bill establishes an October 1, 2015 deadline for the early childhood commissioner to require, as part of the Birth-to-Three program, that notice of the availability of hearing tests be given to parents and guardians of children receiving program services who are exhibiting delayed speech, language, or hearing development. PA 15-81, which the bill repeals, (1) imposes the same deadline for the Department of Developmental Services to require the notice and (2) contains similar notice and regulatory provisions.

The notice required under the bill may include information on the benefits of, and available financial assistance for, hearing tests for children, as well as available hearing test and treatment resources.

The bill allows the commissioner to adopt implementing regulations.

The Birth-to-Three program is a private, provider-based system that provides services to families with infants and toddlers who have developmental delays or disabilities.

EFFECTIVE DATE: July 1, 2015

§ 348 — TRANSFER OF CERTAIN DPH PROGRAMS TO THE INSURANCE FUND

The bill transfers funding for the following Department of Public Health (DPH) programs from the General Fund to the Insurance Fund:

1. needle and syringe exchange,
2. AIDS services,
3. breast and cervical cancer detection and treatment,
4. x-ray screening and tuberculosis care, and
5. venereal disease control.

By September 1st annually, the Office of Policy and Management (OPM) secretary, in consultation with the DPH commissioner, must determine the amounts appropriated for the above listed programs and inform the insurance commissioner.

Public Health Fee

The bill requires all domestic insurers and HMOs ("health carriers") that conduct health insurance business in the state to annually pay the insurance commissioner a "public health fee" she assesses them. The fee must be deposited in the Insurance Fund. Under the bill, "health insurance" applies to coverage for (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

Under the bill, health carriers must annually report to the insurance commissioner the number of insured or enrolled lives in Connecticut as of May 1st immediately preceding the date for which the carrier is providing health insurance coverage. This number must exclude lives enrolled in Medicare or Medicare Advantage plans, Department of Social Services-administered medical assistance programs, or workers' compensation insurance.

Health carriers must report this information by September 1 annually, in a form and manner the commissioner prescribes.

The bill requires the insurance commissioner, by November 1 annually, to determine each health carrier's assessment for the current fiscal year. She must do so by multiplying the number of reported lives by a factor she determines annually to fully fund the DPH programs' appropriation.

The insurance commissioner, by December 1 annually, must provide each assessed health carrier a statement of its proposed public health fee. The carrier may object to the proposed fee by December 20. After making any necessary adjustments, the commissioner must provide a final assessment by January 1. The assessment must be paid to the department by February 1 annually. Any health carrier aggrieved by the assessment may appeal to Superior Court by March 1.

EFFECTIVE DATE: July 1, 2015

§ 349 — NEWBORN SCREENING PROGRAM FEE

The bill increases, from $56 to $98, the fee DPH charges hospitals for administering its newborn screening program.

By law, all health care institutions that care for newborn infants must test them for over 40 genetic and metabolic diseases and conditions, such as phenylketonuria, HIV, and sickle cell disease. Screening occurs primarily through DPH's newborn screening program. The law requires DPH to set a fee that covers all program expenses, including initial testing, tracking of infants, and treatment.

EFFECTIVE DATE: July 1, 2015

§§ 350-353 — BEHAVIORAL HEALTH AND AUTISM SPECTRUM DISORDER SERVICES

1. expands certain individual and group health insurance policies' required coverage of autism spectrum disorder (ASD) services and treatment;

2. expands existing law's group policy behavioral therapy coverage requirements for people with ASD and also applies it to individual policies;

3. eliminates maximum coverage limits on the Birth-To-Three program; and

4. makes technical and conforming changes.

The coverage provisions apply to health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO. Due to the federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured plans.

Covered ASD Services in Individual Policies

The bill requires individual policies to conform to several coverage and limitation provisions that existing law requires of group policies in regard to ASD-related services. Current law requires individual health insurance policies to cover physical therapy, speech therapy, and occupational therapy services for individuals with ASD to the extent that such services are covered for other diseases and conditions under the policy. Under the bill, individual policies must instead cover ASD diagnosis and treatment including:

1. behavioral therapy;

2. prescription drugs prescribed by a licensed physician, physician assistant, or advanced practice registered nurse to treat ASD symptoms and comorbidities, to the extent they are covered for other conditions under the policy;

3. direct (a) psychiatric or consultative services provided by a licensed psychiatrist and (b) psychological or consultative services provided by a licensed psychologist; and

4. physical therapy, speech and language pathology services, and occupational therapy provided by a licensed physical therapist, speech and language pathologist, or occupational therapist, respectively.

Individual policies must cover treatments for individuals with ASD that are:

1. medically necessary;

2. identified and ordered by a licensed physician, psychologist, or clinical social worker; and

3. in accordance with a treatment plan developed by a licensed (a) behavior analyst certified by the Behavior Analyst Certification Board, (b) physician, (c) psychologist, or (d) clinical social worker, pursuant to a comprehensive evaluation or reevaluation.

The bill also specifies ASD constitutes an illness for the purposes of applying the medical necessity definition.

ASD Coverage Limitations and Prohibitions in Individual Policies

The bill prohibits individual policies from:

1. limiting the number of visits an insured may make to an ASD provider pursuant to a treatment plan on any basis other than lack of medical necessity and

2. requiring coinsurance, copayments, deductibles, or other out-of-pocket expenses that place a greater financial burden on access to ASD diagnosis and treatment than the diagnosis and treatment of any other covered medical, surgical, or physical health condition.

The bill prohibits insurers, HMOs, hospital or medical service corporations, and fraternal benefit societies from reviewing a treatment plan, in accordance with its utilization review requirements, more than once every six months unless the insured's licensed physician, psychologist, or clinical social worker agrees a more frequent review is necessary or changes the insured's treatment plan. The bill exempts inpatient treatments and services from this provision.

The bill requires diagnoses be valid for at least one year, unless the insured's licensed physician, psychologist, or clinical social worker determines a shorter period is appropriate or changes an insured's diagnosis.

The bill specifies that coverage is subject to other general exclusions and limitations of individual health insurance policies, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and case management provisions.

The bill also specifies coverage must not be construed to:

1. limit or affect any other covered benefits available (a) under the policy, (b) specific to mental and nervous conditions, or (c) through the Birth-To-Three program;

2. limit or affect any obligation (a) to provide services under an individualized education plan or (b) imposed on a public school by the federal Individuals With Disabilities Education Act; and

3. provide reimbursement for special education and related services, unless required by state or federal law.

Behavioral Therapy Coverage for People with ASD under Group and Individual Health Insurance Policies

Current law defines behavioral therapy under group policies as any interactive behavioral therapy derived from evidence-based research, including applied behavior analysis (see below) and cognitive behavioral therapy. Behavioral therapy also includes other therapies, supported by empirical evidence of their effectiveness in treating individuals with ASD, that are:

1. provided to children under 15, and

2. either provided or supervised by a (a) behavior analyst certified by the Behavior Analyst Certification Board, (b) a licensed physician, or (c) a licensed psychologist. ("Supervised by" is the face-to-face supervision of ASD services for at least one hour for each 10 hours of therapy the supervised individual provides.)

Under current law, such coverage may be subject to a maximum yearly benefit based on the child's age (e.g., $50,000 for a child under age 9).

The bill makes the following changes to the behavioral therapy coverage requirements under group policies:

1. requires therapy be provided to children up to age 21,

2. repeals the yearly coverage limits, and

3. requires therapy be consistent with the services and interventions designated by the Commissioner of Developmental Services (see § 354 below).

By law, "applied behavior analysis" is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior.

By law, group policies must cover treatments for individuals with ASD that are medically necessary; identified and ordered by a licensed physician, psychologist, or clinical social worker; and in accordance with a treatment plan developed by certain licensed professionals. The bill also allows behavior analysts certified by the Behavior Analyst Certification Board to develop treatment plans.

The bill requires individual health insurance policies to cover behavioral therapy subject to the same terms as group policies.

Coverage For Birth-to-Three Services in Individual and Group Health Insurance Policies

The bill repeals coverage limits for services through the Birth-to-Three program. Birth-to-Three provides services to families with infants and toddlers who have developmental delays or disabilities. By law, individual and group health insurance policies must cover medically necessary early intervention services for a child from birth until age three that are part of an individualized family service plan. Current law limits coverage to $6,400 per year per child, up to $19,200 for the three years, except that coverage under a group plan for a child with ASD who is receiving early intervention services is $50,000 per year and $150,000 in total.

EFFECTIVE DATE: January 1, 2016

§ 354 — DSS COMMISSIONER'S DESIGNATED SERVICES AND INTERVENTIONS

The bill requires the developmental services commissioner, in consultation with the Autism Spectrum Disorder Advisory Council, to designate services and interventions that demonstrate, in accordance with medically established and research-based best practices, empirical effectiveness for treating ASD. The commissioner must update the designations (1) periodically and (2) whenever he deems it necessary to conform to changes recognized by the relevant medical community in evidence-based practices or research.

EFFECTIVE DATE: Upon passage

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§ 357 — PRESCRIPTION DRUG MONITORING PROGRAM

Under the prescription drug monitoring program, DCP collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing. By law, pharmacists and other controlled substance dispensers must generally report certain prescription information to DCP under the program, such as the dispensing date, dispenser identification and prescription number, and patient identifying information.

Currently, they must report this information to the program at least weekly. Starting July 1, 2016, the bill requires them to report to the program immediately after dispensing controlled substances but in no event more than 24 hours after doing so. The bill also requires the information to be submitted electronically according to a DCP-approved format. Current law allows other DCP-approved methods of reporting by pharmacies or outpatient pharmacies that do not maintain electronic records.

As under existing law, these reporting requirements apply to (1) pharmacies; (2) nonresident pharmacies (i.e., out-of-state pharmacies that send prescription drugs into the state); (3) outpatient pharmacies in hospitals or institutions; and (4) practitioners who dispense controlled substances.

EFFECTIVE DATE: October 1, 2015

§ 358 — DMHAS ACUTE CARE AND EMERGENCY BEHAVIORAL SERVICES GRANT PROGRAM

The bill establishes a grant program in the Department of Mental Health and Addiction Services (DMHAS) to provide funds to organizations providing acute care and emergency behavioral health services.

The grants are for providing community-based behavioral health services, including (1) care coordination and (2) access to information on and referrals to available health care and social service programs. The commissioner must establish eligibility criteria and an application process.

EFFECTIVE DATE: July 1, 2015

§ 359 — PSYCHIATRIC SERVICES STUDY

The bill requires the DMHAS commissioner to study the current adequacy of psychiatric services. She must do so in consultation with the children and families (DCF) and social services (DSS) commissioners and behavioral health providers, including hospitals and advocacy agencies.

The study must include:

1. a determination of how many short-term, intermediate, and long-term psychiatric beds are needed in each region of the state;
2. the average wait times for each type of bed;
3. the impact of wait times on people needing inpatient psychiatric services, their families, and providers of this type of care;
4. identification of public and private funding sources to maintain the necessary number of beds;
5. access to outpatient services, including wait times for initial appointments;
6. available housing options; and
7. access to alternatives to hospitalization, including peer-operated respite programs.

The DMHAS commissioner must report on this study to the Appropriations, Human Services, and Public Health committees by January 1, 2017. The report must include recommendations on:

1. expanding utilization criteria to increase access to acute, inpatient psychiatric services statewide;
2. increasing the number of available long-term, inpatient hospital beds for people with recurring needs for inpatient behavioral health services;
3. funding to increase the number of psychiatric beds;
4. placing additional psychiatric beds in health care facilities throughout the state; and
5. funding to increase alternatives to hospitalization, including access to outpatient services, housing, and peer-operated respite programs.

EFFECTIVE DATE: July 1, 2015

§§ 360 & 361 — BEHAVIORAL SERVICES PROGRAM

The bill renames the Department of Developmental Services “Voluntary Services Program” as the “Behavioral Services Program” to reflect current practice. The program serves children and adolescents with intellectual disabilities and emotional, behavioral, or mental health needs.

EFFECTIVE DATE: July 1, 2015

§ 362 — STUDY OF COMMUNITY-BASED HEALTH CARE SERVICES

The bill requires the DSS and DPH commissioners to study the effectiveness of providing community-based health care services in the state. They must submit a preliminary report on the study by February 1, 2016, and a final report by June 1, 2016, to the Human Services and Public Health committees.

The study must include at least a review of:

1. the health care needs of people who use the 9-1-1 system when the emergency department is not the most appropriate place for them to receive community-based health care services;

2. the feasibility of providing short-term follow-up home visits for people recently discharged from a hospital until other providers are able to provide home visits or other follow-up health care services;

3. the need and feasibility of emergency medical services (EMS) personnel to provide home visits to people at a high risk of being frequent, repeat users of the emergency department, to help them manage chronic diseases and adhere to medication plans;

4. the need to provide ancillary primary care services for populations in areas with a high 9-1-1 use for nonemergency situations;

5. current best practices in mobile integrated health care;

6. the scope of practice for EMS personnel;

7. practice guidelines for community-based health care services; and

8. Medicaid authority to cover these services.

EFFECTIVE DATE: Upon passage

§§ 363-369 — GENETIC COUNSELOR LICENSING

Subject to certain exemptions, the bill requires anyone practicing genetic counseling to be licensed by DPH. The licensure application fee is $315 and licenses may be renewed annually for $190.

The bill establishes licensure qualifications, application and renewal processes, and grounds for disciplinary action. It allows DPH to issue nonrenewable temporary permits under certain conditions. It also allows the commissioner to adopt regulations to implement genetic counselor licensing and specifies that no new regulatory board is established for genetic counselors.

Under the bill, “genetic counseling” means providing services that address the physical and psychological issues associated with the occurrence or risk of a genetic disorder, birth defect, or genetically influenced condition or disease in an individual or family.

EFFECTIVE DATE: October 1, 2015, except the provisions on licensure applications, qualifications, and renewals are effective on passage.

§ 390 — MEDICATION ADMINISTRATION

The law permits a registered nurse (RN) to delegate the administration of medications that are not injected into patients to homemaker-home health aides who obtain certification for medication administration. Under the law, administration may not be delegated when the prescribing physician specifies that a nurse must administer the medication.

The bill requires the DSS commissioner to monitor Medicaid home health savings that have been achieved since the law's implementation three years ago (PA 12-1 § 11 JSS, effective July 1, 2012). If, by January 1, 2016, the commissioner determines that the savings are less than the amount assumed in the 2016-17 biennial budget, DSS may reduce home health care Medicaid rates for medication administration to the amount necessary to achieve the assumed savings. But before reducing the rate, the bill requires the commissioner to report to the Appropriations and Human Services committees provider specific cost and utilization trend data for patients receiving medication administration in their homes. If DSS determines it is necessary to reduce the medication administration rates, it must examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for the providers, as determined by the commissioner, who have successfully delegated medication administration to homemaker-home health aides as described above.

EFFECTIVE DATE: July 1, 2015

§§ 405-410 & 483-488 — DPH LICENSE RENEWAL FEES

PA 15-244, §§ 112-135, (1) increases by $5 license renewal fees for various DPH-licensed professionals and (2) directs the revenue generated to a newly established account to fund the professional assistance program for DPH-regulated professionals (currently, the Health Assistance InterVention Education Network (HAVEN)). The bill makes the:

1. fee increases effective October 1, 2015 and applicable to registration periods on or after that date, rather than effective July 1, 2015 and

2. DPH commissioner's quarterly certification and transfer of revenue received as a result of the fee effective October 1, 2015, rather than July 1, 2015.

Additionally, the bill eliminates the provision in PA 15-244 § 131 that increases, by $5, the fee for renewing a funeral home inspection certificate.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2015, except for the provision changing the effective date of the fee increases in PA 15-244, which takes effect June 30, 2015.

§ 422 — PAID FAMILY AND MEDICAL LEAVE IMPLEMENTATION

The bill requires the labor commissioner, in consultation with the state treasurer, state comptroller, and commissioner of administrative services, to establish the procedures needed to implement a paid family and medical leave (FML) program.

The labor commissioner must contract with a consultant to create an implementation plan for the program by October 1, 2015. At minimum, the plan must:

1. include a process to evaluate and establish mechanisms, through consultation with the above officials and the Department of Revenue Services, by which employees must contribute a portion of their salary or wages to a paid FML program by possibly using existing technology and payroll deduction systems;

2. identify mechanisms for timely claim acceptance; claims processing; fraud prevention; and any staffing, infrastructure and capital needs associated with administering the program;

3. identify mechanisms for timely distributing employee compensation and any associated staffing, infrastructure, and capital needs; and

4. identify funding opportunities to assist with start-up costs and program administration, including federal funds.

The bill also requires the labor commissioner, by October 1, 2015 and in consultation with the treasurer, to contract with a consultant to perform an actuarial analysis and report on the employee contribution level needed to ensure sustainable funding and administration for a paid FML compensation program.

The labor commissioner must submit a report on the implementation plan and actuarial analysis to the Labor and Appropriations committees by February 1, 2016.

EFFECTIVE DATE: Upon passage

§§ 445 & 446 — NOTICE OF PESTICIDE APPLICATIONS ON SCHOOL GROUNDS

Direct Notice to Parents or Guardians

By law, schools, other than regional agricultural science and technology education centers, must provide certain information of pesticide applications directly to the parents and guardians who register to receive it. Slightly different notice requirements apply based on whether a school has an integrated pest management (IPM) plan. IPM is the use of all available pest control techniques, including judicious pesticide use, when needed, to maintain a pest population at or below an acceptable level, while decreasing pesticide use (CGS §§ 10-231a and 22a-47).

For schools without IPM plans, the bill requires this notice to be sent electronically, rather than by mail as current law requires. Existing law, unchanged by the bill, requires schools with IPM plans to send the information by any means practicable.

The bill also adds the target pest to the information schools with IPM plans must provide when notifying parents about pesticide applications, making it consistent with the information schools without IPM must provide. The law already requires both school types to provide the (1) pesticide's active ingredient, (2) date and location of application, and (3) person who may be contacted for more information.

The bill requires each local or regional board of education to indicate on its website's homepage how parents may register for prior notice of pesticide applications.

Internet and Social Media Notice

Under the bill, for schools with or without IPM plans, beginning October 1, 2015, each local or regional board of education must also, at least 24 hours before applying pesticide in any school building or on school grounds, post the direct notice required under existing law (see above) either on or through the:

1. homepage of the website of the school where the application will occur or, if there is no website, the homepage of the board's website, and

2. school's or board's primary social media account.

Under the bill, "social media" is an electronic medium where users create and view user-generated content, such as uploaded or downloaded videos or photographs, blogs, video blogs, podcasts, or instant messages.

For schools without IPM plans, the online and social media notice requirements must be made at the same time as the electronic notification to registered parents and guardians when there are emergency applications to address human health threats.

Electronic Mail Notification or Alert System

The bill requires a board of education, by March 15 each year, to send through its or its schools' electronic mail notification or alert systems or services (1) the notice required to be sent directly to parents or guardians before a pesticide application (see above) for all applications made since January 1 of the same year and (2) a list of the notices for applications made between March 15 and December 31 of the previous year. A board of education must also include the electronic mail notification in the applicable parent handbook or manual, as long as reprinting the handbook or manual is unnecessary.

Scope of Requirement

The bill specifies a school or board of education is not required to develop or use a website, social media account, or electronic mail notification or alert system that is not already in use or existence as of October 1, 2015.

EFFECTIVE DATE: October 1, 2015

§ 447 — SCHOOL GROUND LAWN CARE PESTICIDE APPLICATION

Existing law prohibits the use of lawn care pesticide on the grounds of preschools and schools with students in grade eight or lower, absent a human health emergency. A "lawn care pesticide" is a pesticide (1) registered by the U.S. Environmental Protection Agency (EPA) and (2) labeled according to federal law for use in lawns, gardens, and ornamental sites or areas.

The bill exempts the following products from this definition, thus allowing their application on the grounds of these schools:

1. EPA-registered microbial or biochemical pesticides;

2. horticultural soaps or oils registered with EPA and without any synthetic pesticide or synergist (enhancer of pesticide properties); and

3. certain pesticides classified by EPA as exempt material, such aspheromones, biological specimen preservatives, and minimum-risk pesticides (40 CFR 152.25).

Under the bill, a "microbial pesticide" is a pesticide that has a microorganism as the active ingredient, and a "biochemical pesticide" is a naturally occurring substance that controls pests by nontoxic means.

EFFECTIVE DATE: Upon passage

§ 448 — PESTICIDE USE AT MUNICIPAL PLAYGROUNDS

Scope of Application Restrictions

The bill restricts pesticide and lawn care pesticide use on municipal playgrounds. The restrictions apply to outdoor areas designated, dedicated, and customarily used for playing by children. This includes areas with a swing set, slide, climbing structure, playset, or device or object that children play on. The bill specifies that it does not cover (1) fields or open space used primarily for sporting activities and (2) playgrounds on school premises.

The restrictions apply to areas owned or controlled by a town, city, borough, consolidated town and city, or consolidated town and borough.

Non-Lawn Care Pesticide Application

Under the bill, only DEEP-certified pesticide applicators may apply pesticide on municipal playgrounds, except in an emergency. Anyone may apply pesticide in an emergency to eliminate an immediate human health threat, such as from mosquitoes, ticks, or stinging insects, if:

1. the executive head of the municipal department responsible for the playground's maintenance or his or her designee (the "controlling authority") finds the application is necessary,
2. he or she decides it is impractical to obtain a certified applicator, and
3. the application does not involve an EPA- or DEEP-restricted use pesticide.

For purposes of applying pesticide on municipal playgrounds, a "pesticide" is a fungicide used on plants, an insecticide, an herbicide, or a rodenticide, but not a sanitizer, disinfectant, antimicrobial agent, or pesticide bait.

Lawn Care Pesticide Application

The bill bans applying lawn care pesticide on municipal playgrounds, absent a human health emergency.

For an emergency lawn care pesticide application to occur under the bill, there must be an immediate threat, such as from mosquitoes, ticks, or stinging insects. The controlling authority must determine the application is necessary, and the application cannot involve an EPA- or DEEP-restricted use pesticide.

The bill applies the same definition of "lawn care pesticide," and the same exceptions provided above, as for applications on school grounds.

Notice

The bill requires public notice of pesticide or lawn care pesticide applications on municipal playgrounds. For a pesticide application, advance public notice must be given, if the situation allows, at least 24 hours before the application. But if the controlling

authority determines an emergency application of pesticide or lawn care pesticide is needed, notice must be given as soon as practicable.

The bill requires the notice to be made by the controlling authority within existing budgetary resources. The notice must be posted on the municipality's website and include the (1) pesticide's active ingredient, (2) target pest, and (3) date or proposed date and location of the application.

Under the bill, the controlling authority must keep a copy of each notice for five years from the pesticide application date. All copies must be available to the public.

EFFECTIVE DATE: October 1, 2015

§ 449 — REGULATIONS ON PESTICIDE APPLICATION RECORDS

By law, the DEEP commissioner, in consultation with the DPH commissioner, must adopt regulations on pesticide application by state agencies, departments, or institutions. Current law requires the regulations to include IPM methods to reduce pesticide use. Under the bill, this requirement applies if the DEEP commissioner provides pertinent model pest control management plans.

The bill also requires the regulations to address record retention by each state agency, department, or institution that applies pesticide or implements an IPM program. The records must at least include the (1) reason for pesticide use, (2) location of pesticide application, (3) application frequency at each location, (4) EPA toxicity category and carcinogenic classification for each pesticide used, and (5) application cost.

EFFECTIVE DATE: Upon passage

§§ 489-490 — REPORTING OF IMPAIRED HEALTH CARE PROFESSIONALS

By law, physicians, physician assistants, and hospitals must notify the DPH if a physician or physician's assistant is or may be unable to practice with skill and safety due to impairment. The law also establishes procedures for DPH to follow when it receives such notice. The bill expands the reporting requirement to cover all licensed or permitted health care professionals.

It establishes similar (1) requirements for hospitals and other licensed or permitted health care professionals to report to DPH suspected impairment that may limit a person's ability to practice with skill and safety and (2) procedures for DPH to follow when it receives such notice.

Under certain circumstances, the bill allows a health care professional or hospital to satisfy the bill's reporting requirements by referring the impaired health care professional for intervention to the professional assistance program for DPH-regulated professionals (currently, the Health Assistance InterVention Education Network (HAVEN)).

Under the bill, covered health care professionals include: chiropractors, naturopaths, podiatrists, athletic trainers, occupational and occupational therapy assistants, physical therapists and physical therapy assistants, radiographers, radiologic technologists, radiologist assistants, nurses, nurse-midwives, dentists, dental hygienists, optometrists, opticians, respiratory care practitioners, psychologists, marriage and family therapists, clinical and master social workers, alcohol and drug counselors, professional counselors, veterinarians, massage therapists, dietitian-nutritionists, acupuncturists, paramedics,

embalmers and funeral directors, hearing instrument specialists and speech and language pathologists.

Petitions (§ 490)

The bill requires health care professionals and hospitals, and allows anyone else, to file a petition when the individual or hospital has information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety because of:

1. physical illness or loss of motor skill, including deterioration due to aging;
2. emotional disorder or mental illness;
3. drug abuse or excessive use, including alcohol, narcotics, and chemicals;
4. illegal, incompetent, or negligent conduct in the professional's practice;
5. possession, use, prescription for use, or distribution of controlled substances or prescription drugs, except for therapeutic or other medically necessary proper purposes;
6. misrepresentation or concealment of a material fact when obtaining or applying for reinstatement of a professional license; or
7. violation of any law or regulation governing the health care professional.

A health care professional or hospital must, and anyone else may, file a petition with DPH within 30 days of obtaining information to support the petition. Each petition must (1) be filed on forms the department supplies, (2) be signed and sworn, and (3) state in detail the reasons for the petition.

Investigations (§ 490)

DPH must investigate all petitions it receives under the bill's provisions to determine if there is probable cause to issue charges and institute proceedings against the professional (see BACKGROUND).

The investigation must be concluded within 18 months after the petition is filed with the department. During that time:

1. the investigation is generally confidential, but the department must provide information to the person who filed the petition and
2. no one may disclose his or her knowledge of the investigation to a third party unless the health care professional being investigated requests an open investigation and disclosure.

After the 18-month period, the investigation record becomes a public record for Freedom of Information Act purposes.

Probable Cause (§ 490)

If DPH determines probable cause exists to charge the health care professional, the entire proceedings record becomes public unless the department determines that the professional is an appropriate candidate for participation in the assistance program.

If, during the 18-month investigation period, DPH finds no probable cause, the petition and the investigation record remain confidential, except (1) the department may provide

the petitioner, upon request, information about the investigation and a chance to review the investigation notes if the petitioner also alleged incompetence, negligence, fraud, or deceit or (2) the professional may request that the petition and record be open.

Physical or Mental Examination (§ 490)

Under the bill as part of an investigation, DPH may order the health care professional to submit to a physical or mental examination by a physician chosen from a DPH-approved list. (Presumably, the professional selects the physician.) DPH may seek advice from established medical organizations or licensed health professionals to determine the nature and scope of diagnostic examinations that such physical or mental examinations should include. The chosen physician must make a written statement of his or her findings.

If the health care professional does not obey a DPH order to submit to an examination or attend a hearing, DPH may petition Hartford Superior Court to order the examination or attendance.

Under the bill, DPH may not restrict, suspend, or revoke a health care professional's license, or limit his or her right to practice, until he or she has been given notice and the opportunity for a hearing in accordance with the Uniform Administrative Procedure Act.

Referrals and Liability (§ 490)

Under the bill, a health care professional or hospital that refers an impaired professional for intervention to the assistance program satisfies the bill's reporting requirement if the impairment is due to chemical dependency, emotional or behavioral disorder, or physical or mental illness.

Additionally, the assistance program and any professional, hospital, or person who files a petition with DPH in accordance with the bill's provisions or provides information to DPH or the assistance program about an impaired professional, are immune from liability for damage or injury to the professional without a showing of malice.

Notification Requirements (§ 490)

The bill requires a health care professional to notify DPH if he or she is (1) arrested for alleged possession, use, prescription for use, or distribution of a controlled substance or prescription drug or alcohol or (2) diagnosed with a mental illness or behavioral or emotional disorder. The professional must provide the notice within 30 days of the arrest or diagnosis and he or she may satisfy the obligation by seeking intervention with the assistance program.

The bill also requires a professional to report to DPH any disciplinary action that was taken against him or her (1) that is similar to those actions DPH may take against professionals under its jurisdiction (e.g., license or permit revocation or suspension) and (2) by another state, the District of Columbia, a U.S. possession or territory, or a foreign jurisdiction. The professional must provide the notice within 30 days of the action.

Under the bill, a health care professional's failure to report may constitute grounds for DPH to take disciplinary action.

Professional Assistance Program Account (§ 489)

PA 15-244, § 137 establishes a professional assistance program account as a separate, nonlapsing account in the General Fund to hold any money that the law requires to be deposited in it effective July 1, 2015. The DPH commissioner must pay the account's funds to the HAVEN program to provide various services (e.g., rehabilitation, intervention, and education, among others) to impaired health care professionals.

But for FY 16 and FY 17, the bill requires up to $400,001 and $586,272, of the account's funds, respectively, to be available to DPH to implement the expanded requirements for reporting impaired health care professionals described above, effective October 1, 2015. The commissioner must then pay any account balance to the HAVEN program.

EFFECTIVE DATE: October 1, 2015

§§ 508-521 — MEDICAL MARIJUANA

The bill makes various changes to the state's medical marijuana program, which the Department of Consumer Protection (DCP) administers.

The bill allows minors to be qualifying patients. In addition to existing requirements for adult patients, the bill requires the consent of the parent or other person with legal custody and a letter by two physicians stating that medical marijuana use is in the minor's best interest.

It adds the following to the list of qualifying conditions for adults: (1) sickle cell disease, (2) Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's Disease), (3) severe psoriasis and psoriatic arthritis, (4) Fabry disease, (5) ulcerative colitis, (6) post-laminectomy syndrome with chronic radiculopathy (recurring back pain after surgery), (7) cerebral palsy, and (8) cystic fibrosis. Earlier this year, the Department began the process to adopt regulations to add the first six of these conditions to the list of qualifying conditions, following recommendations by the Board of Physicians.

It allows licensed (1) marijuana dispensaries to distribute marijuana to licensed inpatient care facilities under certain conditions and (2) nurses to administer marijuana in hospitals or other licensed health care facilities.

It allows the DCP commissioner to approve medical marijuana research programs, and requires research program subjects to register with DCP. It requires the commissioner to adopt regulations on licensing (1) research program employees and (2) laboratories and laboratory employees. These employees must be licensed after the regulations take effect; before then, the bill provides for temporary registration certificates.

The bill allows licensed marijuana dispensaries or producers to distribute marijuana to licensed laboratories or organizations conducting approved research programs. It extends legal protections, under certain conditions, to laboratory or research program employees and research program subjects.

Among other things, the bill also:

1. allows medical marijuana use in the presence of minors who are qualifying patients or research program subjects;

2. requires licensed marijuana dispensaries to annually report certain information to DCP; and

3. removes the requirement that members of the medical marijuana board of physicians be certified in one of certain specialties.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2015

§§ 508-510 & 512 — MINORS AS QUALIFYING PATIENTS

Under current law, only state residents age 18 or older may be qualifying medical marijuana patients. The bill extends the program to state residents under age 18. As under current law, inmates are ineligible.

As for adult patients under existing law, before using marijuana for medical purposes, minors must have a written certification by a physician, who determined that (1) the patient has a debilitating medical condition which the bill limits for minors (see below) and (2) the potential benefits of the palliative use of marijuana would likely outweigh its health risks. (While the law refers to "palliative" rather than "medical" marijuana use, the program is generally referred to as the medical marijuana program.) Patients, and their primary caregivers, must register with DCP and pay certain fees.

The bill creates additional requirements and conditions that must be met for minors to qualify, discussed below.

Written Consent by Parent or Person with Legal Custody

To qualify, a minor must have written consent from a custodial parent, guardian, or other person with legal custody, indicating that the person has given permission for the minor's palliative use of marijuana for a debilitating condition as defined in the bill (see below).

The written consent must also state that the person will (1) serve as the minor's primary caregiver and (2) control the acquisition and possession of marijuana and any related paraphernalia on the minor's behalf.

By law, a medical marijuana patient's primary caregiver is someone at least age 18, other than the patient or the patient's physician, who agrees to take responsibility for managing the patient's well-being with respect to palliative marijuana use. Someone convicted of illegally making, selling, or distributing controlled substances cannot serve as a primary caregiver (CGS § 21a-408b).

Letter from Two Physicians

Under the bill, if the qualifying patient is a minor, the person with legal custody must provide DCP with a letter from the minor's pediatrician and another physician board-certified in an area involved in the treatment of the minor's debilitating condition. The letter must confirm that the palliative use of marijuana is in the patient's best interest.

Qualifying Conditions and Form of Marijuana

The bill allows a minor to use marijuana for terminal cancer; terminal positive status for HIV or AIDS status; irreversible spinal cord injury with objective neurological indication of intractable spasticity; cerebral palsy; cystic fibrosis; epilepsy or uncontrolled intractable seizure disorder; or and other medical conditions, treatments, or diseases that DCP approves through regulations.

It prohibits a dispensary facility from dispensing any marijuana product in a smokable, inhalable, or vaporizable form to a primary caregiver for a patient who is a minor. It similarly prohibits a physician from issuing a written certification for marijuana in a dosage form requiring that the marijuana be smoked or vaporized.

Other Existing Provisions

Otherwise, the bill applies the same program requirements or conditions when minors are patients as for adults under existing law and the bill. For example:

1. schools, landlords, and employers are prohibited from taking certain actions against a medical marijuana patient or caregiver if solely based on the person's status as such, unless the actions are required by federal law or to obtain federal funding;

2. legal protections for medical marijuana patients do not apply if the patient ingests marijuana in certain settings, such as at work or school or in public; and

3. health insurers are not required to cover medical marijuana use.

§§ 510 & 512 — Source of Marijuana

Under the bill, a qualifying medical marijuana patient, when registering with DCP, must select a licensed dispensary facility in the state to obtain his or her marijuana. Once the patient is registered, he or she may purchase marijuana only from the selected facility, except the patient may change facilities in accordance with DCP regulations.

If a registered medical marijuana patient is found to possess marijuana that did not originate from the selected dispensary facility, he or she may be subject to a hearing before the DCP commissioner. This hearing concerns possible enforcement action, such as suspension or registration of the person's registration certificate.

§§ 511 & 514 — Marijuana Use At Licensed Health Care Facilities

The bill allows licensed marijuana dispensaries or their employees to distribute or dispense marijuana to a hospice or other inpatient care facility licensed by the Department of Public Health (DPH). This applies only if the facility has a DCP-approved protocol for handling and distributing marijuana.

The bill extends legal protections to nurses who administer marijuana to qualifying patients or research program subjects in hospitals or health care facilities licensed by DPH. The protections are similar to those under existing law for physicians who issue written certifications for marijuana use as allowed by law.

Thus, the bill prohibits these nurses from being arrested, prosecuted, or otherwise penalized, including being subject to civil penalties, or denied any right or privilege, including being disciplined by the Board of Examiners for Nursing or other professional licensing boards, for administering marijuana as set forth above.

§§ 514-515 & 519-521 — RESEARCH PROGRAMS

Under specified conditions, the bill allows the DCP commissioner to approve medical marijuana research programs (i.e., studies intended to increase knowledge of the growth, processing, medical attributes, dosage forms, administration, or use of marijuana to treat or alleviate symptoms of any medical condition or the symptoms' effects). As described

below, it requires research program employees to be licensed by, and research program subjects to register with, DCP.

Program Approval

The bill allows the DCP commissioner to approve a marijuana research program if it will:

1. be administered or overseen by a DPH-licensed hospital or health care facility, an institution of higher education, or a licensed producer or dispensary and

2. have institutional review board oversight.

Under the bill, an institutional review board is a specifically constituted review body established or designated by an organization to protect the rights and welfare of people recruited to participate in biomedical, behavioral, or social science research.

If the research will involve animals, the program also must have an institutional animal care and use committee. This is a committee overseeing an organization's animal program, facilities, and procedures to ensure compliance with federal policies, guidelines, and principles on animal research.

Research Programs and Employees

The bill requires the DCP commissioner to adopt regulations to:

1. provide for the approval of research programs and licensure of research program employees;

2. set standards and procedures for the termination or suspension of research programs;

3. set standards and procedures for employee license revocation, suspension, summary suspension, and nonrenewal, consistent with Uniform Administrative Procedure Act provisions requiring agencies to give notice and an opportunity to show compliance before revoking or suspending a license, except for summary suspensions when emergency action is needed;

4. set fees for research program review and approval and employee licenses and license renewal, with the aggregate amount of fees at least covering the costs of program approval and the licensing and regulating of research employees under the medical marijuana law; and

5. establish other licensing, renewal, and operational standards the commissioner deems necessary.

After the regulations take effect, no unlicensed person may act as a research program employee or represent that he or she is licensed as such. Before then, the commissioner may issue temporary registration certificates to research program employees. He must prescribe the standards, procedures, and fees for obtaining these certificates.

The bill requires any such program approval, employee licensing, or temporary certificate fees to be paid to the state treasurer for deposit in the General Fund.

It allows licensed dispensaries, or their employees, to distribute or dispense marijuana to organizations engaged in approved research programs. It allows licensed producers or their employees to sell or otherwise distribute marijuana to these organizations.

Current law does not allow qualifying patients to ingest marijuana on college or university property. The bill creates an exception if the institution is participating in an approved research program and the marijuana is used under the terms of that program.

Prohibited Acts and Legal Protections for Research Programs and Employees

The bill prohibits research programs, or their licensed or temporarily certified employees, from:

1. acquiring marijuana from anyone other than a licensed dispensary, producer, or laboratory;

2. delivering, transporting, or distributing marijuana to anyone other than licensed dispensaries or producers or research program subjects;

3. distributing or administering marijuana to animals who are not research subjects; or

4. obtaining or transporting marijuana outside of the state in violation of state or federal law.

The bill extends legal protections to licensed or temporarily certified research program employees who, when acting within the scope of their employment, (1) acquire, possess, deliver, transport, or distribute marijuana to a licensed dispensary or producer or research program subject or (2) distribute or administer marijuana to an animal research subject, under the medical marijuana law. They may not be arrested, prosecuted, or otherwise penalized, including being subject to civil penalties, or denied any right or privilege, including being disciplined by a professional licensing board, for these actions.

Research Program Subjects

The bill requires anyone seeking to participate as a research program subject to first register with DCP. The commissioner must prescribe registration standards and procedures.

The bill generally extends the legal protections noted above to a research program subject with a valid registration certificate, for the use of marijuana while acting within the scope of an approved research program.

However, these protections do not apply to marijuana use in certain settings, similar to the restrictions on medical marijuana users under existing law and the bill. Thus, the protections for research subjects do not apply if the person's marijuana use endangers the health or well-being of someone else, other than a research program employee. The protections also do not apply if the person ingests marijuana:

1. on a motor bus, school bus, or other moving vehicle;

2. at work;

3. on school grounds or any public or private school, dormitory, college, or university property, unless the college or university is participating in a research program and the marijuana use is part of that program;

4. in any public place; or

5. in the presence of a person under age 18 who is not a qualifying patient or research program subject.

Under the bill, information on research program subject registration is generally confidential and not subject to disclosure under the Freedom of Information Act. Similar to existing law for qualifying patients, the bill requires DCP to give reasonable access to this information to certain people for specified purposes (e.g., local, state, and federal agencies for law enforcement purposes or physicians and pharmacists for treatment and monitoring purposes).

§ 516 — Board of Physicians

The bill eliminates the requirement that physicians on the medical marijuana program's board of physicians be certified by the appropriate American board in neurology, pain medicine, pain management, medical oncology, psychiatry, infectious disease, family medicine, or gynecology.

By law, the DCP commissioner must establish a board of eight physicians knowledgeable about palliative marijuana use. Among other things, the board must (1) recommend to DCP additions to the list of debilitating conditions and (2) convene public hearings to evaluate petitions to add conditions to this list.

§524 — REPEAL OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES WORKING GROUP

The bill repeals Section 3 of PA 15-226. The repealed provisions required the insurance commissioner and the healthcare advocate to convene a working group to improve the alignment of utilization review procedures and health insurance coverage with the clinical recommendations of treating health care providers.

EFFECTIVE DATE: Upon passage