

# State of Connecticut

Department of Public Health



## 2009 Legislative Analysis

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# Sources of Information

The following summaries have been compiled from the Office of Legislative Research bill analyses and tailored specifically for the Department of Public Health. Only Public Acts affecting or acts of interest to the Department were included in this issue.

## For Further Information

For more in-depth explanations, information on other Public Acts, or questions on legislative intent, please contact the Office of Government Relations:

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## Availability on the U:/Drive

The 2009 Legislative Analysis is available on the LAN at the following site:  
U:legalert/2009legis/summary/summary.doc

## Availability on the Internet

The 2009 Public Acts and reports are available through the Connecticut General Assembly's web site: <http://cga.ct.gov>

## Acknowledgements

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June 2009

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**Administrative Branch**

Penalties for Violations of Certain Personnel Files Statutes and Equal Pay for Equal Work

Effective: October 1, 2009

**SUMMARY:**

This bill makes several changes to the law banning employers from discriminating based solely on gender in the amount of compensation paid to employees. The bill:

1. expands possible employer defenses against gender wage claims;
2. permits, rather than requires, a court to order awards when an employer is found to violate the law;
3. extends the period to make a claim of discrimination from one to two years following a violation;
4. expands the whistleblower protections to include those who testify or assist in a gender wage proceeding;
5. permits possible compensatory and punitive damages for violations of the whistleblower protections; and
6. repeals the \$ 200 fine for each wage discrimination violation or for retaliatory action against an employee bringing a gender wage complaint.

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Public Act 09-106

HB 6186

Protecting the Integrity of Conn-OSHA Investigations

Effective: October 1, 2009

**SUMMARY:**

By law, a state and local public employee who gives notice to the labor commissioner of a potential occupational safety and health violation or situation with an imminent threat of danger of physical harm may ask and have his or her name removed from any record published, released,

or made available regarding the potential violation or danger. This bill gives this same right to an employee whose name is not part of the original complaint notice, but who at any time provides information to the commissioner regarding the potential violation or danger.

By law, once the commissioner receives such a notice, she may enter the workplace without advance notice for an inspection. Also, she may compile, analyze, and publish, in either summary or detail form, all reports of information obtained under this provision.

The bill specifies that the regulations adopted for the state Occupational Safety and Health Act must be in accordance with the act and the Uniform Administrative Procedure Act.

The bill also makes technical changes.

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Public Act 09-33

HB 6190

*Confidentiality of Certain Employer Data*

Effective: October 1, 2009

**SUMMARY:**

The unemployment compensation act requires employers to provide the Labor Department with employee information that must be kept confidential other than to department employees. There are exceptions to this under specific confidentiality agreements with regional workforce development boards as a part of their duties under the federal Workforce Investment Act.

This bill permits the department to make such information available to a private entity under contract with the U. S. Department of Labor (U. S. DOL) to administer grants that benefit the state Labor Department. It requires the private entities to enter into the same confidentiality agreements that the law requires of the regional workforce development boards.

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Public Act 09-70

SB 710

*Updates to the Family and Medical Leave Act*

Effective: Upon Passage

**SUMMARY:**

This bill permits an employee to take up to 26 weeks in unpaid leave from work under the state family and medical leave (FML) acts to care for an immediate family member or next of kin who is a current member of the U. S. armed forces, National Guard, or the military reserves and is:

- undergoing medical treatment, recuperation, or therapy;
- otherwise in outpatient status; or
- on the temporary disability retired list for a serious injury or illness.

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Public Act 09-210

SB 954

Concerning Personal Service Agreements

Effective: Upon passage, except the NEMT provisions are effective on July 1, 2009 and the provision requiring the annual reports on PSAs is effective October 1, 2009.

**SUMMARY:**

The law establishes two types of contracts that state agencies execute when procuring services from private providers—personal service agreements (PSA) and purchase of services (POS) contracts. PSAs are written agreements defining the services or end product to be delivered by a contractor to a state agency. A POS is a contract between a state agency and a private provider organization or municipality for the purchase of ongoing direct health and human services for agency clients. This bill:

1. requires the Office of Policy and Management (OPM) to provide two reports to the legislature annually on PSA activities;
2. eliminates (a) the requirement that state agencies submit semi-annual reports on their PSA activities and (b) other reporting requirements;

3. prohibits state agencies from hiring certain health or human service providers without first executing POS contracts; and
4. clarifies the POS definition.

The bill also deletes an obsolete reference to purchase orders and makes technical and conforming changes.

The bill also requires any contractor (broker) (1) to which DSS awards a contract to coordinate nonemergency transportation (NEMT) to Medicaid recipients and (2) that also coordinates transportation for individuals not receiving Medicaid to disclose to any transportation provider with which it contracts the source of payment when the transportation service is requested. (If the Medicaid recipient requests the transport from the broker, the broker would not be able to contact the provider at the same time. )

And the bill requires all NEMT brokers to make prior authorization (PA) decisions for nonemergency hospital discharge ambulance trips no later than three business days after the hospital or ambulance company submits the PA request. If the broker fails to communicate a decision by the deadline, the request is deemed approved.

## **PERSONAL SERVICE AGREEMENTS (PSA) AND PURCHASE OF SERVICE (POS) CONTRACTS**

### ***OPM Reports***

Beginning October 1, 2009, the bill requires the OPM secretary annually to submit a report to the General Assembly on PSAs executed during the preceding fiscal year. This information includes the names of the personal service contractor and amounts paid for each contract. Under current law, OPM must submit a summary report on PSA activity annually. The bill removes this requirement.

Currently, the Department of Transportation (DOT), every six months, must report to OPM on PSAs it executed with (1) persons or entities performing consultant services or (2) federal or state agencies. The bill instead requires OPM to provide a separate annual report to the General Assembly on PSAs for these specific types of contracts executed during the preceding fiscal year, as well as those for contractual services, as defined in state law.

By law, personal service contactors are people or entities that state agencies hire to provide services to the agency. They do not include those performing contractual or consultant services, as defined above.

### ***Elimination of Agency Responsibilities***

The bill eliminates the requirement that every six months each state agency submit reports to the OPM secretary on PSAs executed during the previous six months, including contractor names, service descriptions, costs, and payments made.

It also eliminates a requirement that each agency with proposed PSAs costing between \$ 20,001 and \$ 50,000 submit information about the PSAs to OPM at the same time it submits the information to the commissioner of administrative services or the attorney general.

### ***Purchase of Service (POS) Contracts***

The bill codifies current practice by prohibiting state agencies from hiring a private provider organization or municipality to provide direct health or human services to the agency's clients without executing a POS contract with them.

The bill explicitly subjects POS contracts to the same competitive procurement requirements as the law requires for PSAs. The law already authorizes the OPM secretary to waive these requirements for POS contracts.

The bill specifies that POS contracts are generally not for administrative or clerical services, material goods, training, or consulting services and do not include a contract with an individual.

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The bill also defines terms currently in the POS law. For example, it defines a "private provider organization" as a nonstate entity that is either a for- or nonprofit corporation or partnership that receives funds from the state, and may receive federal or other funds, to provide direct health and human services to agency clients.

Public Act 09-214

SB 1162

### ***Concerning Expenditures of Appropriated Funds Other than the General Fund***

Effective: Upon passage

## **SUMMARY:**

This bill requires the Office of Policy and Management (OPM) secretary and the Office of Fiscal Analysis (OFA) director to agree on and issue consensus revenue estimates each year by October 15<sup>th</sup> and to issue any necessary consensus revisions of those estimates in January and April. The estimates must cover the current biennium and the three following years. If the two are unable to issue consensus estimates, the bill requires the comptroller to issue the consensus estimate, which must either equal one of the separate estimates from the two offices or fall between the two.

Under the bill, the consensus revenue estimates and revised estimates must (1) serve as the basis for the governor's proposed budget and for the revenue statement included in the final budget act passed by the legislature to indicate that the budget is balanced, and (2) be included in the annual fiscal accountability reports submitted to the legislature's fiscal committees each November.

If the estimates or revised estimates forecast deficits or increased deficits exceeding certain levels, the bill requires the governor and the legislature's fiscal committees to take specified actions to address the estimates.

Finally, the bill establishes an additional procedure for developing a consensus revenue estimate for the current biennium and requires the governor and legislative fiscal committees to take certain actions based on those estimates if no budget for the biennium has become law by the bill's effective date.

## **ADDITIONAL REQUIREMENTS FOR 2009-11 BIENNIUM**

If no budget for the July 1, 2009 to June 30, 2011 biennium has become law by the bill's effective date, the bill gives the OPM secretary and the OFA director five days after its passage to issue the revised consensus revenue estimate for that biennium. If the offices do not issue the estimate by the deadline, they must issue separate revised estimates. Immediately afterwards, the comptroller must consider the two estimates and issue the revised consensus estimate for the biennium. The estimate must either be the same as the OFA or OPM revised estimate or fall between the two.

Unless a budget for the July 1, 2009 to June 30, 2011 biennium has become law by the bill's effective date, the Appropriations and Finance, Revenue and Bonding committees must, by the 10<sup>th</sup> day after that date, prepare and vote on adjusted appropriations and revenue plans needed to address the revised consensus estimate. Also by the 10<sup>th</sup> day after the bill takes effect, the governor must submit a budget document to the legislature that addresses the revised consensus estimate. The document must be based on the estimate and include drafts of appropriations and revenue bills necessary to address it.

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Public Act 09-111

SB 1167

Concerning a State Deficit Mitigation Plan for the Fiscal Year

Effective: Upon Passage

**SUMMARY:**

This act reduces the projected state General Fund deficit for FY 09 by:

1. reducing FY 09 General Fund appropriations for several agencies and programs by a total of \$22,903,120;
2. reducing FY 09 appropriations from the Special Transportation Fund by \$6,492,122;
3. transferring \$128,677,027 from special funds and non-appropriated accounts to the General Fund as revenue for FY 09; and
4. transferring \$2. 2 million from the OPEB (other post-employment benefits) Teachers' Fund to the retirees health service cost account within the Teacher's Retirement Board in the General Fund for FY 09.

**TRANSFERS TO THE GENERAL FUND FOR FY 09**

The act transfers a total of \$126,677,067 from available balances in special funds and non-appropriated accounts to the General Fund to be counted as General Fund revenue for FY 09. The amount transferred from each fund or account is listed below.

DPH impact;

Sec. 2.

c) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of subsection (c) of section 4-28e of the general statutes, the sum of \$ 5,000,000 shall be transferred from the Tobacco and Health Trust Fund and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

(d) Notwithstanding the provisions of section 19a-73b of the general statutes, the sum of \$ 1,000,000 shall be transferred from the Connecticut Cancer Partnership Account and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

Sec. 3.

(55) The sum of \$ 60,000 shall be transferred from the Emergency Medical Technician Program account, Department of Public Health, and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

(56) The sum of \$ 2,094 shall be transferred from the Woman's Health Summit account, Department of Public Health, and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

(57) The sum of \$ 18,174 shall be transferred from the Care Giver Conference account, Department of Public Health, and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

(58) The sum of \$ 10,000,000 shall be transferred from the Tobacco Health Trust Fund, Department of Public Health, and credited to the resources of the General Fund for the fiscal year ending June 30, 2009.

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## **Healthcare Systems Branch**

Public Act 09-125

HB 5635

*Ultrasound Procedures for Medical and Diagnostic Purposes*

Effective: July 1, 2010

2009 Legislative Analysis

## **SUMMARY:**

This bill prohibits a person from performing an obstetrical ultrasound procedure unless it is (1) for a medical or diagnostic purpose and (2) ordered by a licensed health care provider acting within the scope of his or her practice.

## **BACKGROUND**

### ***Obstetrical Ultrasound***

Ultrasound imaging, also called ultrasound scanning or sonography, involves exposing part of the body to high-frequency sound waves to produce pictures of the inside of the body. Ultrasound exams do not use ionizing radiation (as used in x-rays). Because ultrasound images are captured in real-time, they can show the structure and movement of the body's internal organs, as well as blood flowing through blood vessels.

Obstetrical ultrasound provides pictures of an embryo or fetus within a woman's uterus. During an obstetrical ultrasound, the examiner may evaluate blood flow in the umbilical cord or may, in some cases, assess blood flow in the fetus or placenta. Obstetrical ultrasound is a useful clinical test to:

1. establish the presence of a living embryo/fetus,
2. estimate the age of the pregnancy,
3. diagnose congenital abnormalities of the fetus,
4. evaluate the position of the fetus and placenta,
5. determine if there are multiple pregnancies,
6. determine the amount of amniotic fluid around the baby,
7. check for opening or shortening of the cervix or mouth of the womb, and
8. assess fetal growth and well-being.

**REQUIRED ACTION:** Inform staff about changes and update website to include information about new rules.

Unlicensed Practice of Massage Therapy

Effective: October 1, 2009

**SUMMARY:**

This bill makes it a class C misdemeanor for anyone to engage in the practice of massage therapy or use the title “massage therapist”, “licensed massage therapist”, “massage practitioner”, “massagist”, “masseur”, or “masseuse” without a license from the Department of Public Health.

A class C misdemeanor is punishable by imprisonment for up to three months, a fine of up to \$ 500, or both.

**REQUIRED ACTION:** Inform staff about changes and update website to include information about new rules.

Concerning the Practice of Acupuncture

Effective: October 1, 2009

**SUMMARY:**

This bill provides title protection to licensed acupuncturists and to individuals certified to practice auricular acupuncture for alcohol and drug abuse treatment.

The bill prohibits unlicensed individuals from using the title of “acupuncturist” or advertising acupuncture services. Also, individuals may not use any letters, words, or insignia in connection with their names that indicates or implies that they are licensed acupuncturists.

The bill also prohibits a person from representing himself as certified to practice auricular acupuncture for treatment of alcohol and drug abuse unless certified to do so. A person may not use the term “acupuncture

detoxification specialist,” or the letters A. D. S. or any letters, words, or insignia indicating or implying that he or she is certified to practice auricular acupuncture for alcohol and drug abuse treatment unless certified under the law.

The bill specifies that it should not be construed as preventing someone from providing care, or performing or advertising services within the scope of his or her license or as otherwise authorized by law.

## **BACKGROUND**

### ***Auricular Acupuncture***

Auricular acupuncture is treatment by inserting needles at a specified combination of points on the surface of the outer ear to aid in the detoxification and rehabilitation of substance abusers.

In order to practice auricular acupuncture in the state, the law requires individuals to be certified by an organization approved by the Department of Public Health (DPH). The treatment must be done under the supervision of a licensed physician and in either (1) a private freestanding facility for the care or treatment of substance abusive or dependent persons, licensed by DPH, or (2) a setting operated by the Department of Mental Health and Addiction Services.

**REQUIRED ACTION** : Update Statutes/application materials on website related to Acupuncture and inform staff.

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Public Act 09-22

HB 6301

### ***Concerning the Practice of Pharmacy and Electronic Prescriptions***

Effective: July 1, 2009

### **SUMMARY:**

This bill changes the manner in which pharmacies may receive and store prescriptions for controlled substances. Under current state and federal law, prescriptions for Schedule II substances may not be transmitted or recorded electronically.

## **COMPLIANCE WITH FEDERAL REGULATIONS**

The bill requires all prescriptions to comply fully with the federal Controlled Substances Act instead of Part 306, U. S. Department of Justice, Bureau of Narcotics and Dangerous Drugs-Federal Register Volume 36, No. 80 et seq.

The bill allows pharmacies to make an immediate conversion to an electronic system should the proposed federal regulations be accepted. Current state law, not changed by the bill, allows records to be created and maintained electronically, but the written drug record prevails where a conflict exists as to whether to maintain a written or electronic record (CGS § 21a-244a).

**REQUIRED ACTION** : Provide copy to PLIS Investigative staff. FLIS will educate staff who conduct onsite hospital visits.

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Public Act 09-149

HB 6320

*Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning Substance Abuse Treatment for Adults*

Effective: July 1, 2009 for the plan changes, October 1, 2009 for reports on plan outcomes, and upon passage for the DPH regulatory requirement.

**SUMMARY:**

This bill (1) establishes specific topics, including benchmarks for state-operated programs, the Department of Mental Health and Addiction Services' (DMHAS) state substance abuse plan must address; (2) requires DMHAS to consult with various groups in developing the plan; and (3) requires DMHAS to report on progress in achieving those benchmarks.

It also requires the Public Health Department (DPH), by January 1, 2011, to implement dual licensure for behavioral health care providers who provide both mental health and substance abuse services. It must do this by amending its substance abuse treatment regulations in consultation with DMHAS. The bill appears to address separate DPH licensure regulations for freestanding mental health and substance abuse treatment facilities. But DPH also licenses other behavioral health care facilities (e. g. , psychiatric hospitals) and individual professionals (e. g. , psychologists and clinical social workers) that might provide both of these services.

**REQUIRED ACTION** : Education will be provided to FLIS staff and providers regarding the regulations and the implementation of a dual licensure program for licensed providers who wish to provide both mental health and substance abuse services. Revision of licensing regulations. The department is required to amend the substance abuse treatment regulation and implement a dual licensure program by January 1, 2011.

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Public Act 09-79

HB 6341

*An Act Concerning Competency to Stand Trial*

Effective: Upon Passage

**SUMMARY:**

This bill permits information sharing among health care providers treating or evaluating a defendant who has been, or is believed to be, not guilty due to a mental disease or defect. Currently, there is no express authorization for sharing this information without the defendant's consent.

The bill gives clinical teams evaluating a defendant's competency access to information on treatment dates and locations in the treatment history in the Department of Mental Health and Addiction Service's (DMHAS) database of treatment episodes for the purpose of requesting a release of information from the defendant. It specifies that no treatment in the database can be included in the evaluators' written report or introduced at the competency hearing unless the defendant authorized its release. Under the bill, the limitation in access to information for this purpose does not limit any other lawful release or use of information from the database.

In addition, when a court orders a defendant to be treated to restore his or her competency, the bill requires the clinical evaluating team to give the court-ordered health care provider information they obtained in the course of their evaluation. They must do this within 24 hours of the court's restoration order.

Finally, no later than five business days after a court determines that the defendant (1) will not become competent within the time that he or she can be detained or supervised or (2) has become competent, the person

in charge of the treatment facility, or a designee, must give a copy of its progress report to the clinical team that originally evaluated the defendant. The bill extends the deadline for completing the initial competency exam from 15 calendar to 15 business days.

**REQUIRED ACTION**: Educate staff and provider community.

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Public Act 09-197

HB 6523

*Licensing of Adolescent Substance Abuse Treatment Facilities and Maternity Homes*

Effective: July 1, 2009

**SUMMARY:**

This bill exempts from Department of Public Health (DPH) licensure requirements individuals to whom the Department of Children and Families (DCF) has issued a license for (1) operation of a substance abuse treatment facility or (2) maternity homes (facilities whose purpose is to care for women during their pregnancies and for these women and their newborns). As a corollary, the bill repeals the law requiring maternity homes to get licensed. DCF licenses maternity homes.

The bill further allows non-nursing staff to administer medication to children or youth residing in DCF-licensed substance abuse treatment facilities. The law already allows medication administration by non-nursing staff to people (1) attending day programs, living in residential treatment facilities, or receiving individual and family support under DCF or the Corrections or Developmental Disabilities departments or (2) being detained in juvenile detention centers or living in residential treatment facilities dually licensed by DCF and DPH. This can occur only when the medication is administered by trained personnel under a written order from a doctor or other medical personnel licensed to prescribe.

**REQUIRED ACTION**: Inform FLIS staff and impacted licensees.

Public Health Code Regulations pertinent to maternity homes will need to be repealed, however substance abuse regulations will remain in effect so that FLIS will continue to regulate entities providing services other than those licensed by DCF.

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Prescription Eye Drop Refills

Effective: January 1, 2010

**SUMMARY:**

This bill prohibits certain health insurance policies that provide prescription eye drop coverage from denying coverage for prescription renewals when (1) the refill is requested by the insured less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill requested by the insured does not exceed this amount.

The bill applies only to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services that are delivered, issued, renewed, amended, or continued in the state on or after January 1, 2010.

\*House Amendment "A" (1) removes the definition of "health insurance policy" in the original bill so that the bill no longer applies to an individual policy or benefit plan that provides medical benefits to Medicaid, HUSKY Plan, Charter Oak Health Plan, ConnPACE, or state-administered general assistance recipients; and (2) makes technical changes.

Concerning Solicitation of Clients, Patients or Customers

Effective: October 1, 2009

**SUMMARY:**

This bill makes it a crime for someone to knowingly, for financial gain, procure or attempt to procure a client, patient, or customer at the direction of, request of, or in cooperation with a "provider" as defined by the bill whose purpose is to:

1. seek to obtain benefits under an insurance contract;
2. assert a claim against an insured or an insurance carrier for providing services to the client, patient, or customer; or
3. obtain benefits under or assert a claim against a state or federal health care benefits program or prescription drug assistance program.

The bill labels such a person a “runner. ” It specifies that certain individuals are not runners.

The bill also makes it a crime to solicit, direct, hire, or employ someone as a runner. The penalty for acting as, or hiring, a runner is imprisonment for up to one year, or a fine of up to \$ 5,000, or both.

The criminal penalties do not apply to the referral of individuals between (1) attorneys, (2) health care professionals, or (3) attorneys and health care professionals.

The bill specifies that a “runner” does not include an individual who:

1. procures or attempts to procure clients, patients, or customers for a provider through public media;
2. refers prospective clients, patients, or customers to a provider as otherwise authorized by law;
3. facilitates, presents, or speaks at a meeting, program or seminar that is open to the public and at which information about a provider's services are discussed; or
4. is a bona fide employee of a provider who responds to an inquiry or request for information initiated by a prospective client, patient, or customer.

The bill specifies that it is in addition to, and cannot be interpreted to limit or restrict, the laws that (1) prohibit soliciting individuals to file lawsuits for damages, or soliciting cases for attorneys, or (2) limit communications by attorneys to prospective clients (see BACKGROUND).

\*House Amendment "A" (1) expands the class of people excluded from the definition of runner by also excluding those who (a) facilitate or speak at a public gathering at which information about a provider's services are discussed or (b) are a provider's employee who responds to an inquiry initiated by a prospective client, patient, or customer; (2) adds the provision dealing with other laws that restrict soliciting and limit communications by attorneys with prospective clients; (3) eliminates an exception from the definition of public media for contact or mailings within 40 days of an accident to any person (a) who has been involved in a motor vehicle accident, (b) who has suffered a personal injury, or (c) whose relative has suffered a wrongful death; (4) defines "health care professional"; and (5) makes certain technical changes.

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Public Act 09-46

SB 46

Concerning the Consumer Report Card

Effective: October 1, 2009

**SUMMARY:**

This bill requires:

1. the insurance commissioner to include in the annual health insurance consumer report card the "medical loss ratio" of each insurer and HMO the report discusses;
2. the Insurance Department to prominently display a link to the report card on its website; and
3. each health insurer or HMO to disclose its "medical loss ratio," as reported in the most recent consumer report card, in writing to a person when he or she applies for coverage.

The bill defines "medical loss ratio" as the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in Connecticut. It limits "claims" to medical expenses for services and supplies provided to enrollees, excluding expenses for stop loss coverage, reinsurance, enrollee educational programs, and other cost containment programs or features.

It also applies this definition to the laws requiring a managed care organization (MCO) to give certain information, including medical loss ratio, to the commissioner and plan enrollees. Current law requires an

MCO to disclose to the commissioner and enrollees its “medical loss ratio,” which it describes as the “percentage of the total premium revenue spent on medical care compared to administrative costs and plan marketing.” The bill also changes the date by which an MCO must annually report to the insurance commissioner from May 1 to January 1.

The bill names the report card the “Consumer Report Card on Health Insurance Carriers in Connecticut.” The report card is a comparison guide of all HMOs and the 15 largest insurers that offer managed care plans in Connecticut. The bill changes, from March 15 to October 15, the date by which the insurance commissioner, after consultation with the public health commissioner, must annually develop and distribute the report card.

## **BACKGROUND**

### ***Managed Care Organizations***

The law defines an MCO as an insurer, HMO, hospital or medical service corporation, or other organization delivering, issuing, renewing, or amending individual or group health managed care plans in Connecticut.

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Public Act 09-108

SB 243

### ***Training in Pain Management***

Effective: July 1, 2009

## **SUMMARY:**

This bill requires all nursing home facilities, except residential care homes, to provide at least two hours of annual training in pain recognition and administration of pain management techniques to (1) all licensed and registered direct care staff and (2) nurse's aides who provide direct patient care. Current law requires this for all Alzheimer's special care units or programs.

The law defines a “nursing home facility” as a nursing home, residential care home, or rest home with 24-hour nursing supervision. Although residential care homes are included in the definition of nursing home facilities, they are not licensed as nursing homes. They provide some

limited assistance with activities of daily living but do not provide nursing care.

**REQUIRED ACTION**: Education of FLIS staff regarding the provisions of this bill.

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Public Act 09-150

SB 325

*Pharmacy Errors and Pharmacy Commission Meeting Minutes*

Effective: October 1, 2009

**SUMMARY:**

This bill allows the Department of Consumer Protection (DCP), the Pharmacy Commission, and the Department of Public Health to publicly disclose information that identifies individuals or institutions when it relates to a proceeding where the commission has voted to formally discipline a licensed pharmacist or pharmacy for an error in dispensing medication. Current law allows disclosure of information only in proceedings relating to questions of licensure or the right to practice. The bill does not affect the ability of the DCP commissioner, in the interest of public health, to disclose information gained through the inspection of pharmacies and outlets permitted to sell nonlegend drugs.

The bill also requires the commission to make records of proceedings available to the public upon request. The records must include the name and license number of any pharmacy or pharmacist against whom the commission has recommended formal action.

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Public Act 09-109

SB 451

*Establishing a Silver Alert System*

Effective: July 1, 2009

**SUMMARY:**

This bill requires the Department of Public Safety's (DPS) Missing Child Information Clearinghouse to collect, process, maintain, and disseminate information to assist in locating missing persons who are (1) seniors age 65 and older or (2) mentally impaired adults at least 18

years old. The missing person's relative, legal representative, or nursing home administrator must file a DPS missing person report and attest under penalty of perjury that the missing person meets the eligibility criteria. He or she must notify the clearinghouse or law enforcement agency if the missing person is found.

The bill requires local police departments that receive a report of a missing senior or mentally impaired adult to immediately accept the report and notify all on-duty police officers and other appropriate law enforcement agencies. Current law requires this only for reports of missing children under age 15.

Finally, the bill clarifies that, within existing resources, the clearinghouse may collect, process, maintain, and disseminate information to help locate missing persons other than children, seniors, or mentally impaired adults.

\*House Amendment "A" adds a nursing home administrator to the list of individuals required to: (1) file a missing person's report with DPS, (2) verify the missing person's eligibility for a silver alert, and (3) notify the clearinghouse or law enforcement agency if the missing person is found.

**REQUIRED ACTION**: Educate nursing home administrators and staff.

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Public Act 09-168

SB 455

*The Nursing Home Bill of Rights*

Effective: October 1, 2009

**SUMMARY:**

The state's nursing home patients' bill of rights gives patients entitled to receive Medicaid the specific right to not have the nursing home or chronic disease hospital charge, ask for, accept, or receive any gift, money, or donation in addition to Medicaid payment as a condition of admission, expedited admission, or continued stay at the facility. The bill adds third-party payment guarantees to this prohibition and extends this right to all patients, not just those entitled to receive Medicaid.

The bill also specifies that the rights and benefits conferred in the patients' bill of rights may not be reduced, rescinded, or abrogated by contract.

**REQUIRED ACTION**: Education to staff and providers.

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Public Act 09-145

SB 754

*Technical Changes to the Statutes Regarding Persons with Psychiatric Disabilities and Persons with Substance Use Disorders*

Effective: October 1, 2009

**SUMMARY:**

This bill makes several minor changes in the laws governing Department of Mental Health and Addiction Services (DMHAS) operations. It:

1. repeals separate statutory authority for the superintendent of Blue Hills Hospital to regulate traffic on that facility's grounds;
2. allows the DMHAS commissioner to permit private physicians and psychiatrists to treat patients at DMHAS facilities, instead of requiring him to adopt regulations to permit such treatment; and
3. updates obsolete language describing patients, facilities and facility police, psychiatric conditions, substance abuse, and social workers.

\*Senate Amendment "A" enables the commissioner of children and families' to ask a court to revoke or modify an order committing a child to a child care facility and makes technical changes.

**COMMITMENT REVIEW**

Current law permits the DMHAS and Department of Children and Families (DCF) commissioners and any interested person to ask the court that committed an adult or juvenile to a state psychiatric hospital or "humane institution" to revoke or modify the commitment. The bill eliminates their ability to do this for people committed to humane institutions and specifies they may do this for children committed to

child-care facilities. The law the bill affects does not define a humane institution, but a statute that concerns medical assistance payments defines it as a state psychiatric hospital, community mental health center, treatment facility for children or adolescents, or any facility or program administered by DMHAS, DCF, or the Department of Developmental Services (CGS § 17b-222).

**REQUIRED ACTION** : FLIS staff will need to be educated regarding technical changes especially subsection 8 which permits placement of individuals who no longer require active psychiatric treatment services in RCHs.

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Public Act 09-58

SB 781

*Therapeutic Contact Lenses*

Effective: October 1, 2009

**SUMMARY:**

This bill allows licensed (1) optometrists authorized to practice advanced optometric care to acquire, prescribe, dispense, and charge for contact lenses containing ocular agents-T and (2) prescribing physicians and surgeons to dispense and sell contact lenses that contain a drug. (It appears that "drug," in this context, is not limited to ocular-agents-T. ) "Physician" does not include a homeopathic physician under the bill.

The bill specifies that optometrists, and physicians and surgeons dispensing or selling contact lenses containing ocular agents-T or drugs do not have to meet current law's requirements on packaging and labeling of drug containers.

\*Senate Amendment "A" (1) specifies that licensed prescribing physicians and surgeons can dispense and sell contact lenses containing a drug, instead of allowing physicians and surgeons trained and specializing in eye diseases to prescribe and dispense contact lenses containing ocular agents-T as in the original bill, and (2) adds the exemption language concerning labeling requirements.

**REQUIRED ACTION** : Update Statutes/application materials on website related to Optometrists and inform staff.

*The Assessment of an Administrative Penalty for Violating Regulations  
Concerning Private Occupational Schools*

Effective: October 1, 2009

**SUMMARY:**

The law permits the Department of Higher Education (DHE) commissioner to assess a \$ 500 per day administrative penalty against any private occupational school that violates any provision of the occupational school law. This bill extends the penalty to violations of any applicable regulations.

**REQUIRED ACTION:** Inform staff about changes and update website to include information about new rules.

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*Private Occupational Schools*

Effective: July 1, 2009, except for the provisions concerning (1) hearings for schools whose authorization has been revoked or that have been assessed an administrative penalty and (2) the Board of Governors' authority to enforce orders, which are effective October 1, 2009.

**SUMMARY:**

This bill revises and expands the requirements a private occupational school must meet to operate in the state. It:

1. conforms the law to current Department of Higher Education (DHE) practice by increasing certain existing fees and establishing new ones that private occupational schools must pay to operate in the state;
2. revises the process for a private occupational school to appeal the DHE commissioner's decision to deny or revoke its authorization or assess an administrative penalty; and

3. prohibits Private Occupational School Student Protection Account funds from being used to refund federal student loans if a school becomes insolvent or ceases operating.

*Notification to the Office of Protection and Advocacy for Persons with Disabilities of Department of Mental Health and Addiction Services Client Deaths*

Effective: Upon Passage

**SUMMARY:**

This bill requires the Department of Mental Health and Addiction Services (DMHAS) commissioner to report to the Office of Protection and Advocacy for Persons with Disabilities (OPA) director, the death of any individual receiving inpatient behavioral health services from a DMHAS-operated facility. The OPA director must be notified no later than 30 days after the individual's death.

Current law requires only that the commissioner report to the OPA director incidents in which a person is seriously injured or dies as a result of the use of physical restraint or seclusion in a facility DHMAS operates, licenses, or supports (CGS § 46a-152, 153).

**BACKGROUND**

***OPA Abuse and Neglect Reports***

OPA is an independent state agency whose purpose is to protect and advocate for the civil rights of people with disabilities of all types. State law requires OPA to investigate reports of alleged abuse or neglect of adults ages 18 to 59 with mental retardation and investigate Department of Developmental Services (DDS) client deaths believed to be caused by abuse or neglect (CGS §§ 46a-10, 11). Federal law also authorizes OPA to investigate abuse and neglect allegations of individuals with mental illness who reside in supervised facilities and the community (42 U. S. C. § 10801).

By executive order, the DDS commissioner must report to OPA all deaths of anyone placed or treated under his direction, regardless of whether abuse or neglect may have contributed. State law also requires

him, when he determines that there is “reasonable cause to suspect or believe” that the death of a DDS client was due to abuse or neglect, to notify the OPA director within 24 hours (2002 Executive Order No. 25, CGS § 46a-11c). These reporting requirements apply only to DDS and not to DHMAS client deaths.

**REQUIRED ACTION** : FLIS staff will be educated regarding the provisions of this bill

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Public Act 09-75

SB 989

*The Alzheimer’s Respite Care Program*

Effective: July 1, 2009

**SUMMARY:**

The State-Wide Respite Care Program provides respite care for people with Alzheimer's disease or related disorders, regardless of age, who are not enrolled in the Connecticut Homecare Program for Elders (CHCPE). The bill increases from \$ 30,000 to \$ 41,000 the program's annual income limit and increases its asset limit from \$ 80,000 to \$ 109,000. Beginning July 1, 2009, the bill requires the Department of Social Services (DSS) commissioner to annually increase the income and asset limits to reflect Social Security cost of living adjustments.

The bill requires the commissioner to adopt regulations allowing program participants who demonstrate a need for additional services to receive up to \$ 7,500 for respite care services. Current law limits respite care services to \$ 3,500 annually. (Respite care services other than adult day care also are limited to 30 days annually)

Finally, the bill adds personal care assistant (PCA) services to the list of respite care services the program provides. Respite care services provide short-term relief for family caregivers from the demands of continual care for an individual with Alzheimer's or related diseases. Under current law, they include homemaker services, adult day care, short-term medical facility care, home-health care, and companion services.

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Public Act 09-206

SB 1048

### Health Care Cost Control Initiatives

Effective: July 1, 2009 for the bulk purchasing provisions; October 1, 2009 for the imaging service provision; and January 1, 2010 for the provision on hospitals and outpatient surgical facility billing for hospital-acquired conditions.

#### **SUMMARY:**

This bill requires the commissioners of the departments of Social Services (DSS) and Administrative Services (DAS) and the comptroller, in consultation with the commissioners of the departments of Public Health (DPH) and Insurance, to develop a plan concerning the bulk purchasing of pharmaceuticals. Specifically, the plan must implement and maintain a prescription drug purchasing program and procedures to aggregate or negotiate pharmaceutical purchases for HUSKY Part B, State Administered General Assistance, Charter Oak Plan and ConnPACE recipients, Department of Correction inmates, and people eligible for insurance under the state employees and municipal employee health insurance plans.

The plan must include the state joining an existing multistate Medicaid pharmaceutical purchasing pool. It must determine whether it is feasible to subject some or all of the programs listed above to the preferred drug lists adopted by DSS for its various programs.

The bill requires DSS to submit the plan to the Public Health and Human Services committees by December 31, 2009. The plan must include (1) an implementation timetable, (2) anticipated costs or savings, (3) a timetable for achieving any savings, and (4) legislative recommendations.

The bill also prohibits (1) hospitals and outpatient surgical facilities from seeking payment for costs associated with certain hospital-acquired conditions and (2) specified health care practitioners from charging for certain imaging services.

\*Senate Amendment "A" adds the insurance commissioner to the bulk purchasing consultation process.

\*Senate Amendment "B" adds the provisions on adverse event reporting, nonpayment for certain hospital-acquired conditions, and

imaging services. It also changes the committees that receive the bulk purchasing plan.

\*House Amendment "A" eliminates provisions added by Senate "B" on (1) adverse event reporting and (2) a change to the Medicaid state plan concerning hospital-acquired conditions.

## **PAYMENT FOR HOSPITAL-ACQUIRED INFECTIONS**

The bill prohibits hospitals and outpatient surgical facilities from seeking payment for any increased costs they incur as a direct result of a hospital-acquired condition identified as nonpayable by Medicare according to federal law (see BACKGROUND). This applies regardless of the patient's insurance status or sources of payment (including self-pay) except as otherwise provided by federal law or PA 09-2, § 8.

That state law requires the DSS commissioner to amend the Medicaid state plan to indicate that the approved inpatient hospital rates it pays for Medicaid-eligible patients are not applicable to hospital-acquired conditions that the Medicare program identifies as "nonpayable" (also referred to as "never events") in accordance with a 2005 federal law to ensure that hospitals are not paid for these conditions.

Under the bill, "hospital" means an acute care hospital subject to the federal inpatient prospective payment system. An "outpatient surgical facility" is an entity, individual, firm, partnership, corporation, limited liability company, or association, other than a hospital, providing surgical services or diagnostic procedures for human health conditions that include use of moderate or deep sedation, moderate or deep analgesia or general anesthesia, as these levels are defined by the American Society of Anesthesiologists or by other professional or accrediting entity recognized by DPH.

## **IMAGING SERVICES**

The bill prohibits specified health care providers from charging patients, insurers, or other responsible third-party payors for performing the "technical components" of CAT scans, PET scans, and MRIs if they, or someone under their direct supervision, did not actually perform the service. (The bill does not specify what constitutes the technical components of these imaging services. ) The prohibition applies to physicians, chiropractors, podiatrists, naturopaths, and optometrists.

Under the bill, radiological facilities and imaging centers must directly bill the patient or third party payor for their services. They cannot bill the practitioner who requested the service.

**REQUIRED ACTION**: FLIS staff will be educated and information will be shared with hospitals and outpatient surgical facilities. Provide consultation to DSS, DAS and Comptroller.

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Public Act 09-212

SB 1100

*Medical Group Clinic Corporations*

Effective: July 1, 2009

**SUMMARY:**

This bill authorizes any hospital or health system to organize and become a member of a medical foundation to practice medicine and provide health care services as a medical foundation through its employees or agents who are licensed physicians and through other providers as defined by the bill. Under the bill, a medical foundation is a nonprofit entity that may operate at whatever locations its members select.

The bill (1) allows mergers and consolidations of medical foundations under certain circumstances, (2) allows corporations organized under any other law authorizing the provision of health care services, (3) establishes certain requirements regarding what must appear in the foundation's name, and (4) makes certain conforming changes to other laws.

\*Senate Amendment "A" authorizes any hospital or health system to organize and become a member of a medical foundation instead of authorizing any health system to organize and become a member group clinic corporation, and makes related changes.

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**Laboratory Branch**

Public Act 09-20

HB 6263

Requiring the Administration of a Screening Test for Cystic Fibrosis to Newborn Infants

Effective: October 1, 2009

**SUMMARY:**

This bill requires all health care institutions caring for newborn infants to test them for cystic fibrosis, unless, as allowed by law, their parents object on religious grounds. It requires the testing to be done as soon as is medically appropriate.

Under the bill, the cystic fibrosis test is in addition to, but separate from, the Public Health Department's newborn screening program for genetic diseases and metabolic disorders. That program, in addition to the initial screening test, directs parents of identified infants to appropriate counseling and treatment.

**BACKGROUND**

***Cystic Fibrosis***

Cystic fibrosis is an inherited disorder that occurs in one in every 3,500 live births. It causes the body to produce abnormally thick secretions that clog the lungs, causing infections; obstruct the pancreas, preventing enzymes from breaking down food in the intestines; and block the bile duct, leading to liver damage. Treatment can include digestive enzyme replacement, antibiotics, and careful monitoring.

Most Connecticut birthing hospitals currently offer newborn cystic fibrosis screening on a voluntary basis. John Dempsey and Yale-New Haven hospitals conduct the actual testing.

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**Operations Branch**

Public Act 09-88

HB 5519

Workers' Compensation Premiums and Volunteer Ambulance Companies

Effective: Upon passage and applicable to policies issued or renewed on or after October 1, 2009.

**SUMMARY:**

This bill requires the state-licensed workers' compensation risk rating organization to file with the insurance commissioner a method of computing workers' compensation premiums for volunteer staff of municipal or volunteer ambulance services that does not base the premium primarily on the number of ambulances the service owns. The bill requires the method to be based primarily on ambulance usage as determined by the estimated annual number of service call responses. The new method applies to workers' compensation policies issued or renewed on or after October 1, 2009.

The bill defines municipal or volunteer ambulance services as a volunteer organization or municipality that the public health commissioner licensed to transport patients.

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Public Act 09-121

HB 5894

*Establishing a "Move Over" Law in Connecticut*

Effective: October 1, 2009

**SUMMARY:**

This bill requires a motorist approaching one or more stationary emergency vehicles located on the travel lane, breakdown lane, or shoulder of a highway to (1) immediately slow down to a reasonable speed below the posted speed limit and (2) if traveling in the lane adjacent to the location of the emergency vehicle, move over one lane, unless this would be unreasonable or unsafe.

For these requirements to apply, the emergency vehicle must have flashing lights activated. Under the bill, an "emergency vehicle" includes a vehicle:

1. operated by a member of an emergency medical service organization responding to an emergency call;
2. operated by a fire department or by any officer of the department responding to a fire or other emergency;
3. operated by a police officer;

4. that is a maintenance vehicle, as defined by law; or
5. that is a licensed wrecker.

A violation of these requirements is an infraction, unless the violation results in the injury or death of the emergency vehicle operator, in which case the fines are a maximum of \$ 2,500 and \$ 10,000 respectively.

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Public Act 09-78

HB 6286

*Act Shielding Fire Departments that Install Smoke and Carbon Monoxide Detectors from Liability*

Effective: October 1, 2009

**SUMMARY:**

This bill exempts fire departments from liability for civil damages for personal injury, wrongful death, property damage, or other loss when they deliver or install smoke or carbon monoxide detectors or batteries for these devices at residential premises. The devices must be (1) new (2) meet all applicable current safety and manufacturing standards, (3) installed in accordance with the manufacturer's instructions, and (4) installed or delivered in the department's official capacity.

Under the bill, a "fire department" includes any municipal, independent, or volunteer fire department; fire district; or independent fire company; and members of these entities.

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Public Act 09-80

HB 6463

*Membership on Regional Planning Agencies*

Effective: October 1, 2009

**SUMMARY:**

This bill increases the membership on regional planning agencies (RPAs), which currently operate in five of the state's 15 planning regions. Under current law, each municipality in an RPA region gets two representatives on the RPA. Those with populations over 25,000 get

an additional representative for each additional 50,000 people or fraction thereof.

The bill makes each municipality's chief elected official (CEO) or his or her designee a representative on the RPA, thus increasing each municipality's base representation from two to three. It similarly increases the representation of cities and boroughs within a town and whose boundaries are not conterminous with it. Current law gives these municipalities one representative each on the RPA. The bill makes the city and borough's CEOs or their designees representatives, thus increasing their membership to two.

The state's RPAs are Central Connecticut RPA, Connecticut River Estuary RPA, Greater Bridgeport RPA, Midstate RPA, and Southwestern Connecticut RPA.

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Public Act 09-137

HB 6541

*Municipal Fire Officers*

Effective: October 1, 2009

**SUMMARY:**

This bill requires fire police officers directing traffic to wear at all times, not just after dark or in inclement weather, a traffic vest, orange or lime green raincoat, or other reflectorized orange or lime green outer clothing that meets national, state, and local safety standards. It (1) allows such officers to wear headgear that meets national, state, and local safety standards, as an alternative to the currently required helmet or regulation fire-police dress uniform cap and (2) eliminates the requirement that the helmet be white.

The bill specifically allows a fire chief to appoint fire department members as fire police officers. Under current law, the chief may, within available appropriations, appoint "such number of persons" he or she deems necessary to perform fire police functions. The bill allows officers functioning in their official capacity to exercise their powers and carry out their duties in any town, instead of just adjoining towns. Fire police officers direct traffic and have other responsibilities at fire scenes.

\*House Amendment "A" replaces the original bill, which required certification in adult, child, and infant cardiopulmonary resuscitation and automated external defibrillator use as a condition of Firefighter I certification, and changes the effective date from July 1, 2009 to October 1, 2009.

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Public Act 09-16

HB 6599

Act Concerning Patient Safety Responders

Effective: Upon passage for interhospital transport; October 1, 2009 for stretcher transport.

**SUMMARY:**

This bill permits only licensed or certified ambulance and rescue services to transport patients on stretchers in motor vehicles. The Public Health Department licenses commercial ambulance and rescue services and issues certificates to volunteer and municipal ambulance services. By law, anyone who wilfully violates an emergency medical services law can be fined up to \$ 250, imprisoned for up to three months, or both (CGS § 19a-180(d)(5)).

The bill requires any ambulance used to transport patients between hospitals to meet state regulatory requirements for basic ambulance service, including those concerning medically necessary supplies and services. These regulations require, among other things, one medical response technician and one emergency medical technician in the ambulance, the latter who must attend the patient at all times.

The bill permits a licensed registered nurse, advanced practice registered nurse, physician assistant, or respiratory care practitioner to supplement the ambulance transport if he or she has current training and certification (1) in pediatric or adult advance life support or (2) from the American Academy of Pediatrics' neonatal resuscitation program, as appropriate and based on the patient's condition.

\*House Amendment "A" adds the provisions on ambulance transport between hospitals.

**REQUIRED ACTION** : DPH/OEMS will notify EMS/Public Safety Agencies about this statute update

Enhanced 9-1-1 Service Database

Effective: July 1, 2009

**SUMMARY:**

This bill allows subscriber information in the enhanced 9-1-1 (E 9-1-1) database to be used for enabling emergency notification systems in life-threatening emergencies. Under current law, it may be used only in responding to emergency calls or investigating false or intentionally misleading reports of incidents requiring emergency service.

The bill defines “subscriber information” as the name, address, and telephone number in the E 9-1-1 database of a telephone used to place a 9-1-1 call or in connection with an emergency notification system. It defines an “emergency notification system” as a service that notifies the public of emergencies. It makes confidential and exempt from the Freedom of Information Act subscriber information provided for (1) enabling such systems and (2) the other purposes specified under current law.

The bill outlines procedures governing release and use of database information by database providers, the Office of State-wide Emergency Telecommunications (OSET), the Department of Emergency Management and Homeland Security (DEMHS), and public safety answering points (PSAP).

Act Concerning Mutual Aid or Mobile Support Units and Nuclear Safety  
Emergency Preparedness Program Plans

Effective: October 1, 2009

**SUMMARY:**

This bill eliminates the state's duty to reimburse towns for (1) compensation and actual and necessary travel, subsistence, and maintenance expenses paid to members of a civil preparedness force while in training as members of a mobile support unit and (2) extends state reimbursements to members of any unit that the Department of

Emergency Management and Homeland Security (DEMHS) commissioner orders to emergency duty. These changes apparently conform the law to current practice.

The bill also eliminates the state's duty to reimburse towns for payments for employee death, disability and injury incurred in the course of such training.

The bill specifies that the reimbursements and certain rights, immunities, and powers afforded to first responders apply only when they are ordered to emergency duty by the governor or commissioner. By law, state or municipal employees engaged in officially authorized civil preparedness duties as members of civil preparedness units have the powers, duties, rights, privileges, and immunities and receive compensation incident to their employment. Other civil preparedness personnel have the same rights and immunities as state employees and are entitled to state compensation for their services.

The bill also changes (1) from November 1 to May 1 annually, the deadline by which DEMHS must submit the nuclear safety emergency preparedness program plan to the Office of Policy and Management and (2) from December 1 to June 1 annually the deadline by which the office must approve the plan.

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Public Act 09-28

SB 787

*Act Concerning the International Emergency Management Assistance Compact*

Effective: July 1, 2009

**SUMMARY:**

This bill enacts and commits Connecticut to the terms of the International Emergency Management Assistance Memorandum of Understanding, which provides a legal framework for the Northeastern states and eastern Canadian provinces to help each other manage emergencies and disasters. (Congress authorized this compact in Public Law 110-171. ) The compact is similar to the Emergency Management Assistance Compact for states, which Connecticut adopted in 2000.

Participating jurisdictions (called party jurisdictions) agree to standard operating procedures for mutual aid requests and assistance, which may include the use of emergency forces by mutual agreement.

Jurisdictions that get aid are legally responsible for reimbursing those that provide it, and out-of-state personnel who acted in good faith, and not negligently or recklessly, are immune from liability for any act or omission while rendering aid under the compact.

Connecticut's Emergency Management and Homeland Security Commissioner is the state's compact representative. He must formulate plans and procedures to implement the compact.

The compact may be amended by agreement of the party jurisdictions. Any jurisdiction may withdraw from it by repealing the enacting statute.

All the Northeastern states, except Connecticut, Massachusetts, and Rhode Island, have enacted the compact. Enactment of the bill makes Connecticut a compact member.

**REQUIRED ACTION:** Establish required plans for operation in Connecticut.

Public Act 09-76

SB 1010

*Exposure to Infectious Diseases and Emergency Responders*

Effective: October 1, 2009

**SUMMARY:**

This bill requires hospitals to timely notify an emergency service organization (ESO) when a patient the ESO attended, treated, assisted, handled, or transported to the hospital is diagnosed with infectious pulmonary tuberculosis (but not other infectious diseases). The bill prohibits the hospital from revealing the patient's identity.

The bill requires each ESO to designate an employee or volunteer to (1) receive the notification; (2) initiate notification requests in cases where an ESO member or volunteer reports possible exposure to an infectious disease, including TB; and (3) perform related functions with regard to infectious diseases. The bill allows the designee to name another employee or volunteer to perform these functions if he or she is unavailable.

Under the bill, “infectious diseases” include (1) infectious pulmonary tuberculosis; (2) hepatitis A, B, or C; (3) human immunodeficiency virus (“HIV”), including “AIDS”; (4) diphtheria; (5) pandemic flu; (6) methicillin-resistant staphylococcus aureus (MRSA); (7) hemorrhagic fevers; (8) meningococcal disease; (9) plague; and (10) rabies. “Exposure” means “percutaneous or mucous membrane exposure to the blood, semen, vaginal secretions, or spinal synovial, pleural, peritoneal, pericardial or amniotic fluid of another person.”

\*Senate Amendment “A” allows a designated officer to name a substitute when he or she is unavailable.

**REQUIRED ACTION:** Notify ESOs of new requirements.

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## **Planning Branch**

Public Act 09-148

HB 6600

### *The Establishment of the Sustinet Health Insurance Plan*

Effective: July 1, 2009, except that the sections on identifying uninsured adults and children (§ 14, 15) and Medicaid and public education outreach (§ 13) take effect July 1, 2011, and the three task forces (§§ 16-18) take effect upon passage.

### **SUMMARY:**

This bill establishes a nine-member Sustinet Health Partnership Board of Directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the “Sustinet Plan,” a self-insured health care delivery plan. The bill specifies that these recommendations must address:

1. establishment of a public authority or other entity with the power to contract with insurers and health care providers,

develop health care infrastructure (“medical homes”), set reimbursement rates, create advisory committees, and encourage the use of health information technology;

2. provisions for the phased-in offering of the Sustinet Plan to state employees and retirees, HUSKY A and B beneficiaries, people without employer sponsored insurance (ESI), people with unaffordable ESI, small and large employers, and others ;

3. guidelines for development of a model benefits package; and

4. public outreach and methods of identifying uninsured citizens.

The board must establish a number of separate committees to address and make recommendations concerning health information technology, medical homes, clinical care and safety guidelines, and preventive care and improved health outcomes. The bill also establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about Sustinet and private health care plans.

Finally, the bill creates task forces addressing obesity, tobacco usage, and the health care workforce.

\*House Amendment “A” (1) reduces the board membership from 14 to nine members and changes board representation and corresponding appointing authorities; (2) specifies that the board must offer recommendations to the General Assembly on the governance structure of an entity to oversee and implement the Sustinet Plan which may include establishing a public authority, rather than directing the board to make recommendations on establishing a public authority; (3) makes changes to the list of recommendations that the board may offer, including adding (a) evaluating the implementation of an individual mandate in concert with guaranteed issue, elimination of preexisting condition exclusions, and implementation of auto-enrollment and (b) studying the feasibility of funding premium subsidies for individuals with income between 300% and 400% of the federal poverty level; (4) requires the board to identify all potential funding sources for establishing and administering Sustinet; (5) specifies that the board may develop recommendations (a) permitting the comptroller to offer the Sustinet Plan to state employees, retirees and their dependents, with any changes to health care benefits subject to the collective

bargaining process and (b) ensuring that nonstate public employers are offered the Sustinet Plan; (6) makes changes concerning recommendations for offering Sustinet to those not offered ESI and those offered unaffordable or inadequate ESI; (7) makes changes to provisions of the bill on offering Sustinet to employers through existing channels; (8) eliminates a section on expansion of Medicaid and HUSKY eligibility; and (9) makes technical changes.

\*House Amendment "B" adds the provision subjecting board members to the law on filing statements of financial interests.

## **§ 1 — DEFINITIONS**

The bill defines the "Sustinet Plan" as a self-insured health care delivery plan designed to ensure that its enrollees receive high-quality health care coverage without unnecessary costs. "Public authority" means a public authority or other entity recommended by the Sustinet Health Partnership board of directors.

"Standard benefits package" means a set of covered benefits, as determined by the public authority, with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage mandates that apply to small group health insurance sold in the state. It includes, but is not limited to (1) coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical, and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; identification and treatment of developmental delays from birth through age three; and evidence-based wellness programs; (2) a per individual and per family deductible that excludes drugs and preventive care; (3) preventive care with no copayment; (4) prescription drug coverage with copayments; (5) office visits for other than preventive care with copayments; (6) mental and behavioral health services coverage, including tobacco cessation, substance abuse treatment, and obesity prevention and treatment (these services must have parity with coverage for physical health services); and (7) dental coverage comparable to that provided by large employers in the Northeast.

A "small employer" is a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or

self-employed for at least three consecutive months, which, on at least 50% of its working days during the preceding twelve months, employed up to 50 people, the majority of whom worked in the state.

## **§ 2 —THE SUSTINET HEALTH PARTNERSHIP BOARD OF DIRECTORS**

### ***Board Members***

The bill establishes the SustiNet Health Partnership board of directors consisting of nine members as follows:

1. the state comptroller;
2. the healthcare advocate;
3. a representative of the nursing or allied health professions, appointed by the governor;
4. a primary care physician, appointed by the Senate president pro tempore;
5. a representative of organized labor, appointed by the House speaker;
6. an individual with expertise in the provision of employee health benefit plans for small businesses, appointed by the Senate majority leader;
7. an individual with expertise in health economics or policy, appointed by the House majority leader;
8. an individual with expertise in health information technology, appointed by the Senate minority leader; and
9. an individual with expertise in actuarial sciences or insurance underwriting, appointed by the House minority leader.

The comptroller and healthcare advocate serve as board chairpersons.

Initial appointments must be made by July 15, 2009. If an appointing authority fails to appoint a member by July 31, 2009, the Senate

president pro tempore and the House speaker jointly make that appointment. A quorum is five members.

Board members' terms are staggered. The initial term for the member appointed by the governor is two years. For those appointed by the House and Senate majority leaders, the term is four years. For the House and Senate minority leaders' appointments, the term is three years. And the term is five years for the appointments of the House speaker and Senate president pro tempore. After the initial term, board members serve five-year terms.

Within the 30 days before a term expires, the appointing authority can reappoint a current member or appoint a new one. Board members can be removed by their appointing authority for misfeasance, malfeasance, or willful neglect of duty.

The bill specifies that any individual serving on the board is subject to existing law on filing a statement of financial interests.

The bill specifies that the board is not a department, institution, or agency of the state.

### **§ 3 — DUTIES OF THE SUSTINET BOARD OF DIRECTORS**

#### ***Designing the Sustinet Plan***

The Sustinet Health Partnership board of directors must design and establish procedures to implement the "Sustinet Plan. " The Sustinet Plan must be designed to:

1. improve the health of state residents;
2. improve the quality of health care and access to health care;
3. provide health insurance coverage to Connecticut residents who would otherwise be uninsured;
4. increase the range of health care insurance coverage options available to residents and employers; and
5. slow the growth of per capita health care spending both in the short-term and in the long-term; and

6. implement reforms to the health care delivery system that will apply to all Sustinet Plan members. But provided any reforms to health care coverage provided to state employees, retirees, and their dependents must be subject to applicable collective bargaining agreements.

By January 1, 2011, the board must submit its design and implementation procedures in recommended legislation to the Appropriations and the Finance, Revenue, and Bonding committees.

### ***Designing the Public Authority***

The board must offer recommendations to the General Assembly on the governance structure of the entity that is best suited to oversee and implement the Sustinet Plan. These recommendations may include, but are not limited to, the establishment of a public authority authorized to:

1. adopt guidelines, policies and regulations necessary to implement the bill's provisions;
2. contract with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers, taking into account their capacity and willingness to offer networks of participating providers both within and outside the state and their capacity and willingness to help finance the administrative costs involved in the establishment and initial operation of the Sustinet Plan, and reimbursing them using per capita fees or other methods that do not create incentives to deny care;
3. solicit bids from individual providers and provider organizations to insure adequate provider networks and provide all Sustinet Plan members with timely access to high-quality care throughout the state and, in appropriate cases, outside the state;
4. establish appropriate deductibles, standard benefit packages, and out-of-pocket cost-sharing levels for different providers that may vary based on quality, cost, provider agreement to refrain from balance billing Sustinet Plan members, and other factors relevant to patient care and financial sustainability;
5. commission surveys of consumers, employers, and providers on issues related to health care and health care coverage;

6. negotiate on behalf of Sustinet Plan providers to obtain discounted prices for vaccines and other health care goods and services;
7. contract for such professional services as financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, and bio-ethicists as the board deems necessary;
8. purchase reinsurance or stop loss coverage, set aside reserves, or take other prudent steps that avoid excess exposure to risk in administering a self-insured plan;
9. enter into interagency agreements for performance of Sustinet Plan duties that may be implemented more efficiently or effectively by a state agency;
10. set payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;
11. appoint advisory committees to successfully implement the Sustinet Plan, further the objectives of the authority, and secure necessary input from various experts and stakeholder groups;
12. establish and maintain an Internet web site that provides for timely posting of all public notices issued by the authority or the board and such other information either deems relevant in educating the public about the Sustinet Plan;
13. evaluate the implementation of an individual mandate in concert with guaranteed issue, the elimination of preexisting condition exclusions,, and the implementation of auto-enrollment;
14. raise funds from public and private sources outside of the state budget to contribute toward support of its mission and operations;

15. make optimum use of opportunities created by the federal government for securing new and increased federal funding, including increased reimbursement revenues;

16. if the federal government enacts national health care reform, submit preliminary recommendations for implementing the Sustinet Plan to the General Assembly, not later than 60 days after federal enactment; and

17. study the feasibility of funding premium subsidies for individuals with income between 300% and 400% of the federal poverty level (FPL).

The bill specifies that all state and municipal agencies, departments, boards, commissions and councils must fully cooperate with the board in carrying out these purposes.

#### **§ 4 — SUSTINET PLAN**

The board of directors must develop the procedures and guidelines for the Sustinet Plan which must comport with these five Institute of Medicine (IOM) principles:

1. health care coverage should be universal;
2. health care coverage should be continuous;
3. health care coverage should be affordable to individuals and families;
4. the health insurance strategy should be affordable and sustainable for society; and
5. health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

The board must identify all potential funding sources that may be used to establish and administer the Sustinet Plan.

The board must recommend that the public authority establish action plans with measurable objectives in such areas as:

1. effective management of chronic illness,
2. preventive care,
3. reducing racial and ethnic disparities in health care and health outcomes, and
4. reducing the number of uninsured state residents.

The board must include recommendations that the authority monitor the progress made toward achieving these objectives and modify the action plans as necessary.

### **§§ 1 AND 5 — HEALTH INFORMATION TECHNOLOGY**

The bill delineates how electronic health records will be established for Sustinet members and how participating providers may gain access to hardware and approved software for interoperable electronic medical records. For these purposes, the bill defines:

1. "electronic medical record" as a record of a person's medical treatment created by a licensed health care provider and stored in an interoperable and accessible digital format;
2. "electronic health record" as an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across multiple health care organizations;
3. "subscribing provider" as a licensed health care provider that (a) either is a participating provider in the Sustinet plan or provides services in the state and (b) agrees to pay a proportionate share of the cost of health care technology goods and services, consistent with board-adopted guidelines; and
4. "approved software" as electronic medical records software approved by the board, after receiving recommendations from the information technology committee the bill establishes.

### ***Information Technology Committee and Plan Development***

The board must establish an information technology committee to make a plan for developing, acquiring, financing, leasing, or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers.

The plan must include the development of a periodic payment system that allows subscribing providers to acquire approved software and hardware and to receive other support services for the implementation of electronic medical records.

### ***Software and Hardware Options and Availability***

The committee must make recommendations on (1) providing approved software to subscribing providers and participating providers (the bill does not define this term), consistent with the bill's capital acquisition, technical support, reduced-cost digitization of existing records, software updating, and software transition procedures and (2) developing and implementing procedures to ensure that individual providers and hospitals have access to hardware and approved software for interoperable electronic medical records and establishment of electronic health records for SustiNet Plan members.

The information technology committee must consult with technology specialists, physicians, nurses, hospitals and other health care providers to identify potential software and hardware options that meet the needs of the full array of health care practices. Any recommended electronic medical records packages the committee recommends for possible purchase must interact with other pertinent practice management modules including patient scheduling, claims submission, billing, and tracking of laboratory orders and prescriptions.

Any recommended system must also include:

1. automated patient reminders concerning upcoming appointments;
2. recommended preventive care reminders;
3. automated provision of test results to patients when appropriate;
4. decision support, including notice of recommended services not yet received by a patient;

5. notice of potentially duplicative tests and other services;
6. notice of potential drug interactions and past adverse drug reactions to similar medications;
7. notice of possible violation of patient wishes for end-of-life care; and
8. notice of services provided inconsistently with care guidelines.

The committee must make recommendations on procuring and developing approved software. These recommendations may include that any approved software be able to gather information to help the board assess health outcomes and track the accomplishment of clinical care objectives. The board must ensure that SustiNet Plan providers who use approved software can electronically transmit to, and receive information from, all laboratories and pharmacies participating in the plan, without the need to construct interfaces other than those constructed by the authority.

The committee must make recommendations on selection of public vendors to provide reduced-cost, high-quality digitization of paper medical records for use with approved software. The vendors must be bonded, supervised and covered entities under the federal Health Insurance Portability and Accountability Act, that is, subject to the act's privacy requirements.

### ***System Integration***

The information technology committee must make recommendations on a system of integrating information from subscribing providers' electronic medical records systems into a single electronic health record for each SustiNet Plan member. This integrated record must be updated in real time and accessible to any participating or subscribing provider serving the member.

The bill requires all recommendations on electronic health and medical records to be developed in a manner consistent with board approved guidelines for safeguarding privacy and data security and with state and federal laws, including any recommendations of the U. S. Government Accountability Office. These guidelines must include recommended remedies and sanctions in cases where guidelines are not

followed. The remedies can include termination from the network or reimbursement denial or reduction.

The committee must recommend methods to coordinate the development and implementation of electronic medical health records in concert with the Department of Public Health (DPH) and other state agencies to ensure efficiency and compatibility. The committee must determine appropriate financing options, including financing through the Connecticut Health and Educational Facilities Authority.

### ***Condition of Participation in Sustinet***

Under the bill, the committee must recommend that use of board-approved or compatible electronic medical records become a condition of provider participation in the Sustinet plan by July 1, 2015, with possible time extensions or exemptions made for providers who would face hardship in meeting the time frame and whose participation in Sustinet is necessary to assure geographic access to care. It authorizes the board to provide additional support to these providers. (But it is not clear what kind of support the board can provide. )

The bill includes specific incentives to help providers meet the goal of adoption of electronic medical records by July 1, 2015. The committee must develop and implement appropriate financial incentives for early subscriptions by participating providers, including discounted fees.

The committee must develop recommended methods to eliminate or minimize transition costs for providers, who, before January 1, 2011, implemented comprehensive electronic medical or health records systems. This can include technical assistance in transitioning to new software and development of modules to help existing software connect to the integrated system.

The committee must make recommendations that subscribing providers share systemic cost savings achieved by implementing electronic medical and health records. The amount of savings the board shares with a provider is limited to the amount of net financial loss the provider experienced during the first five years of the implementation process.

The committee must also make recommendations on the use of electronic health records to encourage the provision of medical home functions (see below). Electronic health records must generate automatic

notices to medical homes that (1) report when an enrolled member receives services outside the medical home, (2) describe member compliance or noncompliance with provider instructions, and (3) identify the expiration of refillable prescriptions.

## **§ 6 — MEDICAL HOMES**

### ***Medical Home Advisory Committee***

The board must establish a medical home advisory committee composed of physicians, nurses, consumer representatives, and other qualified individuals chosen by the board. The committee must develop recommended internal procedures and proposed regulations for the administration of medical homes serving to Sustinet Plan members. The committee must forward its recommendations to the board.

### ***Medical Home Functions***

Committee recommendations must include that (1) the board define medical home functions on an ongoing basis, incorporating evolving research on delivery of health care services and (2) if provider infrastructure limits prevent all Sustinet Plan members from enrolling in a medical home, then enrollment be implemented in phases with priority given to members where cost savings appear most likely, including members with chronic health conditions.

The committee, subject to revision by the board, must make recommendations that initial medical home functions include:

1. Assisting members to safeguard and improve their own health by:
  - a. advising members with chronic health conditions on how to monitor and manage their conditions;
  - b. working with members to set and accomplish goals related to exercise, nutrition, and tobacco use, among other behaviors;
  - c. implementing best practices to insure members understand and can follow medical instructions; and

d. providing translation services and culturally competent communication strategies.

2. Care coordination that includes:

a. managing transitions between home and hospital;

b. monitoring to ensure members receive all recommended primary and preventive care services;

c. providing basic mental health care, including screening for depression, with referral for those who require more help;

d. addressing workplace, home, school, and community stress;

e. referring to nonmedical services such as housing, nutrition, domestic violence programs, and support groups; and

f. ensuring information about members with complex health conditions is shared when multiple providers are involved and that they follow a single integrated treatment plan; and

3. Providing 24-hour access by telephone, secure email, or quickly scheduled office appointments in order to reduce the need for hospital emergency room visits.

The committee may develop quality and safety standards for medical home functions that are not covered by existing professional standards, which may include care coordination and member education.

The committee must recommend to the board that the public authority assist in developing community-based resources to enhance medical home functions, including (1) making loans available on favorable terms that help with development of necessary health care infrastructure, including community-based providers of medical home services and community-based preventive care service providers; (2) offering reduced price consultants to help health care providers restructure their practices and offices to function more effectively and efficiently in response to changes in health care insurance coverage and service delivery attributable to SustiNet implementation; and (3) the offering of continuing medical education courses for physicians, nurses, and other

clinicians, including training in culturally competent delivery of health care services.

### ***Health Care Providers Who Can Serve as a Medical Home***

Under the bill, the committee must make recommendations on entities that can be a medical home including that (1) a licensed health care provider who is capable of providing all core medical home functions as prescribed by the board can serve as a medical home and (2) a group practice or community health center serving as a medical home must identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board, (1) a specialist may serve as a medical home and (2) a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.

The committee must make recommendations on the medical home provider's responsibilities. These include that (1) each medical home provider be given a list of all medical home functions and (2) if a provider does not wish to perform certain functions outside core medical home functions in his or her office, the provider must arrange for other qualified entities or individuals to perform these functions in a way that integrates them into the medical home's clinical practice.

These other entities or individuals must be certified by the board based on the quality, safety, and efficiency of the service they provide. At the medical home provider's request, the board must make all arrangements required for a qualified entity or individual to perform any medical home function (not just non-core functions) the core provider does not assume.

### ***Reimbursement***

The committee must make recommendations concerning payment for medical home functions including that (1) all of the bill's medical home functions are reimbursable under the Sustinet Plan; (2) in setting payment levels for those functions that are not normally reimbursed by commercial insurers, payment cover the full cost of services; and (3) rate-setting mechanisms can include using Medicare rate-setting methods or setting a monthly case management fee.

The committee must make recommendations that specialty referrals include prior consultation between the specialist and the medical home to determine whether the referral is medically necessary. If so, the consultation must identify any tests or procedures that must be done or arranged by the medical home, before the specialty visit, to promote economic efficiencies. The bill requires the Sustinet Plan to reimburse the medical home and specialist for time spent on consultations.

## **§ 7 — HEALTH CARE PROVIDER COMMITTEE; CLINICAL CARE AND SAFETY GUIDELINES**

The bill requires the board to establish a health care provider committee to develop clinical care and safety guidelines for use by Sustinet providers. The committee must choose from existing nationally and internationally recognized care guidelines. It must continually assess the quality of evidence, the relevant costs, and the risks and benefits of treatments. It must forward its recommendations to the board. The committee must have provider and consumer members.

Under the bill, the committee must make recommendations that participating Sustinet providers receive confidential reports comparing their practice patterns with their peers. The report must include opportunities for continuing education.

The committee must make recommendations on quality of care standards for particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition, adjusted for patient risk and general consistency of care with approved guidelines and other factors. The committee must recommend that providers who meet or exceed the standards for a particular condition be publicly recognized and made known to Sustinet members, including those who have been diagnosed with that particular medical condition.

The committee must recommend procedures requiring hospitals and their staffs, physicians, nurse practitioners, and other participating providers to periodically conduct quality of care reviews and develop quality of care improvement plans. Such reviews must identify potential problems manifesting as adverse events or events that could have resulted in negative patient outcomes. As appropriate, they must incorporate confidential consultation with peers and colleagues, opportunities for continuing medical education, and other interventions and supports to improve performance. To the maximum extent

permissible, the reviews must incorporate existing peer review mechanisms. The committee's recommendations must include that any review conducted be subject to the law's protections concerning peer review (CGS § 19a-17b).

The board, in consultation with the committee, must develop safety standards for implementation in hospitals. The board must establish procedures to monitor and impose sanctions to ensure compliance with the standards. It may also establish performance incentives to encourage hospitals to exceed such safety standards.

The committee must make recommendations concerning the authority providing participating providers with information about prescription drugs, medical devices, and other goods and services used in health care delivery. This information can address emerging trends involving the use of goods and services that the authority judges are less than optimally cost effective. The committee must make recommendations on providing free samples of generic or other prescription drugs to participating providers. And the committee must recommend policies and procedures to encourage participating providers to furnish Sustinet members with appropriate evidence-based health care.

## **§ 8 — PREVENTIVE HEALTH CARE AND COMMUNITY-BASED PREVENTIVE HEALTH INFRASTRUCTURE**

The bill requires the board of directors to establish a preventive health care committee that uses evolving medical research to make recommendations to improve health outcomes for members (presumably Sustinet members) in areas of nutrition, physical exercise, tobacco use, addictive substances, and sleep, taking into account programs already underway in the state. The committee must include providers, consumers, and others chosen by the board. These recommendations may be targeted to special member populations where they are most likely to benefit members' health. They can include behavioral components and financial incentives for participants. Beginning July 1, 2010, the committee must annually submit its recommendations to the board.

The board must recommend that the Sustinet plans sold to employers or individuals cover community-based preventive care services that can be administered safely in community settings. Examples of these services are immunizations, simple tests, and health care screenings; and examples of locations are workplaces, schools, or other community

locations. The board must recommend that community-based preventive care providers must use the patient's electronic health record to confirm that the service has not been provided before and is not contraindicated. They must furnish test results or documentation of the service to the patient's medical home or primary care provider.

## **§ 9 — ENROLLMENT OF VARIOUS GROUPS IN SUSTINET**

### ***Nonstate Public Employers; State Employees, Retirees and Dependents; Nonprofits; and Small Businesses***

The board may develop recommendations that ensure that, beginning July 1, 2012, nonstate public employers are offered the benefits of the Sustinet Plan. The bill defines “nonstate public employer” as a municipality or other political subdivision of the state, including a board of education, quasi-public agency, or public library. The board may develop recommendations that permit the comptroller to offer the Sustinet Plan benefits to state employees, retirees, and their dependents (no date is specified in the bill for doing this). No changes in health care benefits can be implemented concerning plans administered according to the state employee health plan unless they are negotiated and agreed to by the state and the coalition committee (SEBAC) through the collective bargaining process.

Also under the bill, the board must develop recommendations that ensure that beginning July 1, 2012, employees of nonprofit organizations and small businesses are offered Sustinet Plan membership.

### ***HUSKY PLAN Part A and B Beneficiaries***

The board must develop recommendations to ensure that the HUSKY Plan Part A and Part B, Medicaid, and state-administered general assistance (SAGA) programs participate in the Sustinet Plan. These recommendations must also ensure that HUSKY Plan Part A and B benefits are extended, to the extent permitted by federal law, to adults with income at or below 300% of FPL.

### ***Those Not Offered Employee Sponsored Insurance (ESI)***

The bill requires the board to make recommendations to ensure that state residents not offered employer sponsored insurance (ESI) and who do not qualify for HUSKY Part A and B, Medicaid, or SAGA can enroll in Sustinet beginning July 1, 2012. These recommendations must ensure

that premium variation based on member characteristics does not exceed in total amount or in consideration of individual health risk, the variation permitted for a small employer carrier.

### ***Those Offered Unaffordable or Inadequate ESI***

The board must make recommendations to provide an option for enrollment in Sustinet to state residents who are offered ESI whose household income is 400% of FPL or less. The board may make recommendations for establishing (1) a procedure for those individuals who demonstrate eligibility to enroll in Sustinet according to this provision and (2) a way to collect payments from employers whose employees would have received ESI, but instead enroll in Sustinet.

## **§ 10 — OFFERING SUSTINET TO EMPLOYERS THROUGH EXISTING CHANNELS**

The bill requires the board to make recommendations concerning (1) use of various ways to sell Sustinet to employers, including public and private purchasing pools, agents, and brokers; (2) offering multi-year contracts to employers that have predictable premiums; (3) policies and procedures to ensure that employers can easily and conveniently purchase Sustinet plan coverage for their workers and dependents including participation requirements, timing of enrollment, open enrollment, enrollment length, and other matters deemed appropriate by the board; (4) policies and procedures to prevent adverse selection. (“adverse selection,” in this context, means purchase of Sustinet Plan coverage by employers with unusually high-cost employees and dependents under circumstances where premium payments do not fully cover the probable claims costs of the employer's enrollees); (5) availability of Sustinet Plan coverage for small employers on and after July 1, 2012 with premiums based on member characteristics as permitted for small employer carriers; (6) availability of Sustinet plan coverage for larger employers with premiums to prevent adverse selection, taking into account past claims experience, changes in characteristics of covered employees and dependents since the most recent time period covered by claims data, and other board-approved factors; and (7) the availability of a standard benefits package that cannot be any less comprehensive than the model benefits packages established by the bill (see § 12).

## **§ 11 — INFORMATION CLEARINGHOUSE**

Under the bill, the board must recommend the establishment of an independent information clearinghouse to provide employers, individual consumers, and the general public with information about the care covered by the Sustinet Plan and by private health plans. The Office of the Healthcare Advocate (OHA) is responsible for establishing the clearinghouse and contracting with an independent research organization to operate it.

The clearinghouse must develop data specifications that show comprehensive information about quality of care, health outcomes for particular health conditions, access to care, patient satisfaction, adequacy of provider networks, and other performance and value information. OHA must develop the specifications in consultation with the board and private insurers.

The board must recommend that the Sustinet Plan and health insurers must submit data to the clearinghouse, the latter as a licensing condition. Self-insured group plans may provide data voluntarily; dissemination of any information such a plan provides is limited, based on negotiations between the clearinghouse and the plan.

The clearinghouse must make its information public and update it annually. It must avoid disseminating information that identifies individual patients or providers. To the extent possible, it must also, adjust outcomes based on patient risk levels.

The clearinghouse must collect data based on each plan's provision of services over continuous 12-month periods. The clearinghouse must make public all information required by this section, subject to the limitations described above, no later than August 1, 2013, with updated information provided annually each August.

## **§ 12 — MODEL BENEFITS PACKAGES**

The bill requires OHA, within available appropriations, to develop model benefit packages that contribute the greatest possible amount of health benefit for enrollees, based on evolving medical and scientific evidence, for the premium cost typical of private, employer-sponsored insurance in the Northeast. By December 1, 2010, and then biennially, the office must report to the board on the updated model benefit package.

After receiving these models, the board may modify the standard benefit package if it believes an adjustment would either yield better health outcomes for the same expenditure of funds, or provide additional health benefits or reduced cost-sharing for particular groups that justify an increase in net costs. Any modification of the standard benefit package by the board must ensure compliance with statutory coverage mandates and utilization review requirements.

OHA must recommend guidelines for an incentive system to recognize employers who provide employees with benefits that are equivalent to or better than the model benefit packages.

By December 1, 2012, OHA must report on these guidelines and recommendations to the governor, comptroller, and the Public Health, Labor and Public Employees, and Appropriations committees.

### **§ 13 — PUBLIC EDUCATION AND OUTREACH CAMPAIGNS**

The bill requires the board to develop recommendations for education and outreach campaigns to inform the public of Sustinet's availability and encourage enrollment. These campaigns must use community-based organizations to reach underserved populations. They must be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. The board must continuously evaluate their effectiveness and change strategy as needed.

### **§ 14 — IDENTIFICATION OF THE UNINSURED**

The board, in collaboration with state and municipal agencies, must, within available appropriations, develop and implement recommendations to identify uninsured individuals. Such recommendations may include:

1. the Department of Revenue Services modifying state income tax forms to ask taxpayers to identify existing health coverage for each household member;
2. the Department of Labor modifying its unemployment insurance claims forms to request information about health insurance status for applicants and their dependents; and

3. hospitals, community health centers, and other health care providers identifying uninsured individuals who seek health care and transmitting such information to the board.

### **§ 15 — IDENTIFYING UNINSURED CHILDREN**

The bill directs the Department of Social Services and education commissioners to consult with the board in their existing obligation to jointly establish procedures for sharing data from the National School Lunch Program to identify income eligible children for enrollment in or HUSKY A and B. And it permits these procedures to cover enrollment in the SustiNet Plan.

### **§ 16 — OBESITY TASK FORCE**

The bill creates a task force to study childhood and adult obesity. It must examine evidence-based strategies for preventing and reducing obesity and develop a comprehensive plan that will result in a reduction in obesity.

The task force includes the following members:

1. a representative of a consumer group with expertise in childhood and adult obesity, appointed by the House speaker;
2. two academic experts in childhood and adult obesity, one each appointed by the Senate president pro tempore and the governor;
3. two representatives of the business community with expertise in the subject, one each appointed by the House majority and minority leaders; and
4. two health care practitioners with expertise on the topic, one each appointed by the Senate majority and minority leaders.

These members, except for the governor's appointee, may be members of the General Assembly.

The commissioners of public health, social services, and economic and community development and a representative of the SustiNet board are ex-officio, non-voting members. Appointments must be made within 30 days after the effective date of this provision, and the first meeting must be held within the same time frame. Vacancies are filled by the

appointing authority. The members appointed by the House speaker and the Senate president pro tempore serve as chairpersons. The first meeting must be held within 30 days after the bill's passage. The Public Health Committee staff serves as the task force's administrative staff.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees. The task force terminates when the report is submitted or January 1, 2011, whichever is later.

## **§ 17 — TOBACCO USE TASK FORCE**

The bill establishes a task force to study tobacco use by children and adults. It must examine evidence-based strategies for preventing and reducing tobacco use and developing a comprehensive plan to reduce in tobacco use. Its members are as follows:

1. a representative of a consumer group with expertise in tobacco use by children and adults, appointed by the House speaker;
2. two academic experts in the field, one each appointed by the Senate president pro tempore and the governor;
3. two representatives of the business community with expertise on the topic, one each appointed by the House majority and minority leaders; and
4. two health care practitioners with expertise in the field, one each appointed by the Senate majority and minority leaders.

These task force members may be legislators, except for the governor's appointee.

The commissioners of public health, social services, and economic and community development and a representative of the Sustinet board are ex-officio, non-voting members. Appointments must be made, vacancies filled, and meetings held as described for the obesity task force. The chairpersons are the members appointed by the House speaker and the Senate president pro tempore.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees. It terminates when it submits the report or January 1, 2011, whichever is later. The Public Health Committee staff serves as administrative staff.

## **§ 18 — HEALTH CARE WORKFORCE TASK FORCE**

The bill establishes a task force to study the state's health care workforce. It must develop a comprehensive plan for preventing and remedying state-wide, regional, and local shortages of necessary medical personnel. Its members are as follows:

1. a representative of a consumer group with expertise in health care, appointed by the House speaker;
2. one academic expert on health care workforce, appointed by the Senate president pro tempore;
3. one academic expert in health care, appointed by the governor;
4. two representatives of the business community with expertise in health care, one each appointed by the House majority and minority leaders; and
5. two health care practitioners, one each appointed by the Senate majority and minority leaders.

The commissioners of public health, social services, and economic and community development, the president of UConn, the chancellors of the Connecticut State University System and the regional Community-Technical Colleges, and a representative of the Sustinet board are ex-officio, non-voting members. Members, except for the governor's appointee, can be members of the General Assembly. Appointments must be made, vacancies filled, and meetings held as described above for the previous two task forces. The chairs are the members appointed by the House speaker and the Senate president.

The Public Health Committee staff serves as administrative staff for the task force. The task force must report by July 1, 2010 to the Public Health, Human Services, and Appropriations committees. The task force terminates as described above.

### **BACKGROUND**

#### ***Legislative History***

The House referred the bill (File 615) to the Insurance and Real Estate Committee on May 5. That committee reported out a substitute bill on

May 6 (File 920) that makes numerous changes to the original file. The substitute creates the 14-member Sustinet Health Partnership Board of Directors instead of a nine-member Sustinet Authority. It also directs the board to make legislative recommendations on the design and implementation of the Sustinet Plan, rather than providing those details as in the original file. The substitute eliminates a number of provisions in the original bill including the creation of a "Sustinet Account," a "shared responsibility" requirement for certain employers and employees involving payments to the account, automatic enrollment, eligibility redetermination, evaluation of outcomes and policy changes, reporting requirements, indemnification of Sustinet Authority personnel and officers, and certain definitions.

**REQUIRED ACTION**

Participation in Task Forces Only: Planning branch will participate in HIT, Quality of Care, and Healthcare Workforce Task Force. The Healthcare Systems Branch will participate in Standards of Care. The Public Health Initiative Branch will participate in the Prevention, Obesity, and Tobacco Use Task Forces.

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Public Act 09-13

SB 899

*Implementing the Guarantee of Equal Protection Under the Constitution of the State for Same Sex Couples*

Effective: Upon passage, except the repeal of the civil union statutes and some conforming provisions are effective October 1, 2010.

**SUMMARY:**

This bill redefines "marriage" as the legal union of two persons. On October 1, 2010, it transforms civil unions into marriages unless they have been annulled or the couple has divorced or is in the process of dissolving their relationship. It exempts clergy; churches; and IRS-qualified, church-controlled organizations from officiating or

participating in a marriage ceremony that violates their religious freedom or beliefs. It also (1) provides certain other religious organizations legal protections for refusing to provide services related to marriage ceremonies; (2) leaves unchanged the authority of fraternal benefit societies to determine membership and beneficiaries; and (3) permits religiously-affiliated organizations that provide adoption, foster care, or social services to operate in the manner they choose so long as the specific program or purpose does not receive state or federal funds.

The bill also repeals provisions in current law that:

1. declare that the current public policy of the state is limited to marriage between a man and a woman and
2. define marriage as the union of one man and one woman.

It establishes a rule controlling when marriages or substantially similar relationships formed in other jurisdictions must be recognized in Connecticut and gives other jurisdictions the discretion to recognize marriages and substantially similar relationships formed in Connecticut.

Many of the bill's provisions conform statutes to the Connecticut Supreme Court's decision in *Kerrigan v. Dept. of Public Health*, which held that it was unconstitutional to restrict marriage to a man and a woman.

It also makes minor, technical, and conforming changes.

\*Senate Amendment "A" adds provisions concerning (1) legal protections for religious organizations; (2) fraternal benefit societies; and (3) adoption, foster care, or social services provided by religiously-affiliated providers.

\*Senate Amendment "C" specifies that the provision on adoption, foster care, or social services applies only to specific programs that receive governmental funding.

## **§§ 11-13 — CIVIL UNIONS**

Beginning on the date the bill passes and until September 30, 2010, parties to Connecticut civil unions may apply for marriage licenses if they are eligible to marry. After the marriage is solemnized and the license certificate is filed with the appropriate vital statistics registrar, their civil union becomes a marriage by operation of law.

On October 1, 2010, civil unions that have not been dissolved or annulled, or are in the process of being dissolved, merge into marriages by operation of law. The bill states that the mergers do not impair or affect any action or proceeding brought before October 1, 2010, any accrued right or benefit, or any responsibility incurred prior to that date. The relationships that have not merged on October 1, 2010 because of pending dissolution, annulment, or legal separation are governed by the civil union statutes in effect on September 30, 2010.

## **§§ 501-503—RELIGIOUS EXEMPTIONS**

### ***Religious Organizations***

The bill specifies that a religious organization, association, or society; or any nonprofit institution or organization operated, supervised, or controlled by one of these entities is not required to provide services, accommodations, advantages, facilities, goods or privileges to an individual if:

1. the request is related to the solemnization of a marriage or celebration of a marriage and
2. the solemnization or celebration is in violation of its religious beliefs and faith.

It specifies that the refusal does not subject the entity to civil liability or allow the state to penalize or withhold benefits from it.

### ***Fraternal Benefit Societies***

The bill specifies that the state's marriage laws cannot be construed to affect the ability of a fraternal benefit society to determine who to admit as members under state law or to decide the scope of legal beneficiaries. The marriage laws also cannot require an existing fraternal benefit society that is (1) operated, supervised, or controlled by, or in connection with, a religious organization and (2) operating for charitable and educational purposes to provide insurance benefits to any person if doing so would violate the society's constitutional rights to free exercise of religion.

### ***Church-Related Adoption, Foster Care. Or Social Service Providers***

The bill states that nothing in its provisions can be deemed or construed to affect the manner in which a religious organization provides adoption, foster care, or social services if the entity does not receive state or federal funds for the specific program or purpose.

#### **§§ 4 — ELIGIBILITY TO MARRY**

The bill's marriage eligibility provisions require that the parties be:

1. not parties to another marriage or substantially similar relationship, except couples who are already married to one another or in substantially similar relationships can marry;
2. at least 18 years of age, unless their parents consent to marriage at age 16 or 17 or a probate judge grants permission to marry at a younger age;
3. not under a conservatorship, unless the conservator consents; and
4. not so closely related that their marriage would be incestuous under Connecticut law.

With the exception of provision (1) above, these requirements are the same as existing marriage laws.

#### **§§ 1& 2 — MARRIAGE RECOGNITION**

The bill requires recognition of marriages or relationships that provide substantially the same rights, benefits, and responsibilities between two people entered into in other jurisdictions and recognized as valid in that jurisdiction. These relationships include same-sex and common law marriages and civil unions. State case law already provides for recognition of common law marriage.

It also allows other states to recognize marriages and substantially similar relationships entered into in Connecticut if the spouse or both spouses travel to or reside in the other jurisdictions, so long as the relationship would be recognized in Connecticut.

#### **§§ 17 & 18 — STATUTORY CONSTRUCTION**

The bill repeals a statute that provides that a number of laws should not be construed to:

1. mean that the state condones homosexuality or bisexuality, or any equivalent lifestyle;
2. authorize the promotion of homosexuality or bisexuality in educational institutions or require the teaching in educational institutions of homosexuality or bisexuality as an acceptable lifestyle;
3. authorize or permit the use of numerical goals or quotas or other types of affirmative action programs with respect to homosexuality or bisexuality in the administration or enforcement of a number of laws;
4. authorize the recognition of same-sex marriage; or
5. establish sexual orientation as a specific and separate cultural classification in society.

The bill repeals the civil union statutes, effective October 1, 2010.

## **BACKGROUND**

### ***Kerrigan v. Dept. of Public Health***

In *Kerrigan v. Dept. of Public Health*, 289 Conn. 135 (2008), the Connecticut Supreme Court ruled that it was unconstitutional to deny same-sex couples the right to marry. The court's opinion expressly did not affect civil unions.

**REQUIRED ACTION** : Distribute a letter to the 169 towns to inform local registrars of the new Public Act and to clarify some of its provisions.

## The Connecticut Health Information Network

Effective: October 1, 2009

### **SUMMARY:**

This bill allows state agencies participating in the Connecticut Health Information Network (CHIN) to disclose personally identifiable information in their data bases to the CHIN administrator and its subcontractors for (1) network development and verification and (2) data integration and aggregation to allow for responses to network inquiries. Such disclosure is subject to federal restrictions on disclosure or redisclosure of such information. The CHIN administrator and CHIN subcontractors must not disclose personally identifiable information.

The bill prohibits state agencies participating in CHIN from disclosing information to CHIN if it would be a violation of federal law, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act of 1974 and associated regulations.

### **BACKGROUND**

#### **CHIN**

State law (CGS § 19a-25e) authorizes the Department of Public Health (DPH) and the UConn Health Center (UCHC), within available appropriations, to develop a CHIN plan. This plan is to integrate state health and social services data within and across the UCHC, the Office of Health Care Access (OHCA), DPH, and the Developmental Services (DDS), and Children and Families (DCF) departments. Data from other state agencies may be integrated into the network as funding and federal law permit. The CHIN must securely integrate this data consistent with state and federal laws.

The law requires DPH and UCHC's Center for Public Health and Health Policy to collaborate with the Department of Information Technology and DDS, DCF, and OHCA in developing the CHIN plan. The plan must:

1. include research in and describe existing health and human services data;

2. inventory the various health and human services data aggregation initiatives currently underway;
3. include a framework and options for implementing CHIN, including ways to use the network to get aggregate data on the state's key health indicators;
4. identify and comply with confidentiality, security, and privacy standards; and
5. include a detailed cost estimate for implementation and potential funding sources.

**REQUIRED ACTION** : Monitor the CHIN Development. DPH Planning Branch is to review UCONN Center for Public Health and Health Care Policy Feasibility Plan, CHIN development modules, and CHIN protocols.

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## **Public Health Initiative Branch**

Public Act 09-179

HB 5018

### *Reviews of Health Insurance Benefits Mandated in this State*

Effective: July 1, 2009

#### **SUMMARY:**

This bill establishes a health benefit review program within the Insurance Department to evaluate the social and financial impacts of mandated health benefits.

The bill requires the insurance commissioner to review mandated health benefits existing or effective on July 1, 2009. He must report findings to

the Insurance and Real Estate Committee by January 1, 2010. It requires the committee, annually by August 1, to give the commissioner a list of any mandated health benefits it wants reviewed. The commissioner must review those benefit and report findings to the committee by the next January 1. The reports must include specified information (see below).

The bill requires the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct the reviews. It authorizes the center's director, as he or she deems appropriate, to (1) retain an actuary, quality improvement clearinghouse, health policy research organization, or other independent expert and (2) engage or consult with any UConn dean, faculty, or other personnel.

The bill requires the Insurance Fund to pay for the review program. It authorizes the commissioner to assess insurers for the program's costs. It specifies that the assessment is in addition to any other taxes, fees, and money the insurers pay to the state. The bill requires the commissioner to deposit payments with the state treasurer, who must credit them to the Insurance Fund as expenses recovered from insurers.

## **MANDATED HEALTH BENEFIT**

The bill defines “mandated health benefit” as a statutory obligation of, or proposed legislation that would require, an insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity offering health insurance or benefits in Connecticut to:

1. allow an insured or plan enrollee to obtain health care treatment or services from a particular type of health care provider;
2. offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or
3. offer or provide coverage for (a) a particular type of health care treatment or service or (b) medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

The term includes proposed legislation to expand or repeal an existing health insurance or medical benefit statutory requirement.

**REQUIRED ACTION:** Establish a health benefit review program within the Insurance Department and through a contract with The University of Connecticut Center for Public Health and Health Policy.

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Public Act 09-188

HB 5021(VETOED)

Wellness Programs and Expansion of Health Insurance

Effective: July 1, 2010

**SUMMARY:**

The bill requires certain health insurance policies to include (1) coverage for prosthetic devices, and repairs and replacements to them, subject to specified conditions; (2) specified coverage for human leukocyte antigen testing; (3) a “reasonably designed” health behavior wellness, maintenance, or improvement program that gives participants one or more of the following: (a) a reward; (b) health spending account contribution; (c) premium reduction; or (d) reduced copayment, coinsurance, or deductible; and (4) coverage for licensed physician- or advanced practice registered nurse-prescribed wigs for a person with hair loss caused by a diagnosed medical condition other than androgenetic alopecia.

The bill also increases (1) the annual coverage amount required for medically necessary ostomy appliances and supplies, from \$ 1,000 to \$ 5,000 and (2) increases the age which certain insurance policies must cover hearing aids as durable medical equipment from 13 to 19.

The bill also prohibits certain health insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a second or subsequent colonoscopy a physician orders for an insured person in a policy year.

\*House Amendment “A” adds the provisions relating to prostheses, human leukocyte antigen testing, wellness incentives, wigs, hearing aids, and colonoscopies.

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Public Act 09-14

HB 6379

Implementing the Governor's Budget Recommendations Concerning  
Maximization of Pharmacy Rebates

Effective: Upon Passage

**SUMMARY:**

Federal Medicaid law establishes two different formulas for calculating drug rebates for drugs dispensed to Medicaid recipients – one for single source innovator (brand-name) drugs and another for noninnovator multiple source drugs (generics). Retroactive to February 1, 2008, this bill requires the rebates the Department of Social Services (DSS) collects from drug manufacturers whose products are provided to Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE) and State-Administered General Assistance (SAGA), and Connecticut AIDS Drug Assistance Program (CADAP) recipients to equal the rebates it collects for Medicaid recipients. For the other DSS pharmacy assistance programs, the bill establishes a lower rebate for innovator and single source drugs.

The bill also:

1. prohibits DSS from paying for any prescription drugs of manufacturers that do not provide rebates unless DSS has determined that a particular manufacturer's drug is medically necessary for one of DSS' clients;
2. specifies that drug manufacturers must provide rebates only after their drug has been on the market for a certain period of time;
3. requires participating manufacturers to notify DSS when they are providing rebates, on a form DSS prescribes, and requires DSS to provide notice to them when it establishes a new pharmacy assistance program;
4. removes a requirement that DSS have an application form and issue certificates for every manufacturer providing rebates; and
5. permits DSS to enter into additional contracts for supplemental rebates for drugs on its preferred drug list.

\*House Amendment "A" makes drugs dispensed to CADAP recipients eligible for the Medicaid-level rebate.

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Public Act 09-223

HB 6684

Establishing A Correctional Staff health and Safety Subcommittee of the Criminal Justice Policy Advisory

Effective: October 1, 2009

**SUMMARY**

This bill requires the Criminal Justice Policy Advisory Commission to establish a subcommittee on correctional staff health and safety. It must be composed of the (1) commissioners of correction, public safety, and mental health and addiction services, or their designees; (2) eight persons appointed one each by the chairpersons and ranking members of the Judiciary and Public Safety and Security committees; (3) one representative from each of the three local chapters of labor organizations representing correction officers, appointed by the local chapter; and (4) one representative from each of the labor organizations representing hazardous duty staff of the Department of Correction (DOC), appointed by the labor organization.

The bill requires the subcommittee to review DOC's policies and procedures on staff health and safety. The review must include the manner in which:

1. inmate assaults are investigated, classified, and assigned points;
2. data on inmate assaults is collected and compiled; and
3. data on inmate assaults is reported to people and agencies outside the department.

The bill requires the subcommittee to submit any recommendations it may have to the commission concerning revisions to policies and procedures.

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Public Act 09-224

HB 6693

Establishing A Correctional Staff health and Safety Subcommittee of the Criminal Justice Policy Advisory

Effective: Upon passage, except that the flag provision is effective July 1, 2009.

**SUMMARY:**

This bill (1) authorizes the state librarian to establish the Real Property Electronic Recording Advisory Committee prior to October 1, 2009, rather than on or after this date; (2) repeals the requirement for state agencies to include a cost-benefit analysis of volunteer services in their annual report to the governor; (3) designates several days, one week, and one month to heighten public awareness of various issues; and (4) requires that national and Connecticut state flags purchased after July 1, 2009 and displayed on state-owned or -leased public buildings be manufactured in the United States.

\*House Amendment "A" (1) adds the designations of Self Injury Awareness Day, Mitochondrial Disease Awareness Week, Thomas Paine Day, and Canada Appreciation Day; (2) combines Honor Our Heroes Day in the original file with the current Remembrance Day; (3) adds the flag provision; and (4) makes technical changes to the designations in the original file.

**STATE DESIGNATIONS**

The bill requires the governor to proclaim:

1. September as Arnold-Chiari Malformation Awareness Month to heighten public awareness of its symptoms and treatments;
2. August 23<sup>rd</sup> of each year as Missing Persons Day to raise awareness of the plight of families of state citizens who have been reported as missing;
3. May 12<sup>th</sup> of each year as Fibromyalgia Awareness Day to heighten public awareness about its symptoms and treatments;
4. September 13<sup>th</sup> of each year as Fragile X Awareness Day to heighten public awareness of its symptoms and treatments;

5. March 1<sup>st</sup> of each year as Self Injury Awareness Day to increase awareness of the issues surrounding self injury;
  6. The third week in September of each year as Mitochondrial Disease Awareness Week to raise awareness of the disease;
  7. January 29<sup>th</sup> of each year as Thomas Paine Day to honor the author and theorist for his role in the cause of American independence; and
  8. July 1<sup>st</sup> of each year as Canada Appreciation Day to honor the close geographic, cultural, and economic ties between the United States and Canada.
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Public Act 09-115

SB 301

*Health Insurance Coverage for Autism Spectrum Disorders*

Effective: January 1, 2010

**SUMMARY:**

This bill broadens what a group health insurance policy must cover regarding autism spectrum disorders. It requires a policy to cover the diagnosis and treatment of autism spectrum disorders, including behavioral therapy for a child age 14 or younger and certain prescription drugs and psychiatric and psychological services for insureds with autism.

By law, a group health insurance policy must cover physical, speech, and occupational therapy services provided to treat autism to the same extent that it covers them for other diseases and conditions. The bill removes that limitation, but specifies different conditions for coverage of the therapy and other services. It permits a policy to set a certain annual dollar maximum for behavioral therapy coverage.

The bill authorizes an insurer, HMO, hospital or medical service corporation, or fraternal benefit society to review an autism treatment plan's outpatient services in accordance with its utilization review requirements more often 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 specifies that it is not to be interpreted as limiting or affecting (1) other covered benefits under the policy, the state mental and nervous condition insurance law, and the birth-to three coverage law; (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law; or (3) any obligation imposed on a public school by the federal Individual with Disabilities Education Act (20 USC § 1400).

The bill also specifies that it must not be interpreted to require a group health insurance policy to provide reimbursement for special education and related services provided to an insured under state law that requires boards of education to provide special education programs and services unless state or federal law requires otherwise.

The bill defines "autism spectrum disorders" as the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," including autistic disorders, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

\*Senate Amendment "A" (1) defines "autism spectrum disorder," (2) specifies that it may not be interpreted to require insurers to reimburse for special education programs and services, (3) changes the definition of behavioral therapy and limits it to children under age 15, (4) eliminates a non-cancellation provision, (5) alters the coverage prohibitions, (6) alters the policy limits for behavioral therapy, and (7) makes technical changes.

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Public Act 09-41

SB 458

*Requiring Communication of Mammographic Breast Density Information to Patients*

Effective: October 1, 2009

**SUMMARY:**

This bill requires all mammography reports (i. e. , written results of a mammogram) given to a patient on and after October 1, 2009 to include information about breast density based on the American College of Radiology's Breast Imaging Reporting and Data System (BIRADS). When applicable, the report must include the following notice:

“If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report. ”

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## **Regulatory Services Branch**

Public Act 09-181

HB 5254

### **Extending the Time of Expiration of Certain Land Use Permits**

Effective: Upon Passage

#### **SUMMARY:**

This bill gives developers more time to complete ongoing projects. It does so by resetting the statutory deadlines planning and zoning commissions and inland wetland agencies may impose on projects they approved between July 1, 2006, and July 1, 2009, inclusive. The deadlines currently range from within two to five years for wetlands projects to 10 years for large-scale residential and commercial projects. In some cases, current law allows the commissions and agencies to extend the deadlines for up to 10 years from a project's approval date.

The bill's deadlines apply to all projects except large-scale residential and commercial projects approved under a site plan review. The new deadlines range from six to 11 years after a project's approval date. In some cases, the bill allows zoning and planning commissions to extend six-year deadlines to 11 years after the project's approval. The extensions do not apply for large-scale housing and business

development projects approved under a site plan review. The bill also allows wetlands agencies to extend a permit's expiration date for up to 11 years.

\*House Amendment "A" narrows the range of projects subject to the bill's deadlines to those approved between July 1, 2006 and July 1, 2009. Under the original version of the bill, the deadlines applied to projects approved on or before July 1, 2009.

## PROJECT COMPLETION DEADLINES

The bill resets the initial and extended deadlines that apply to subdivisions, wetlands permits, and relatively small-scale site plans that were approved between July 1, 2006, and July 1, 2009, inclusive. It does not affect projects with approval dates outside this timeframe. The table below highlights this change.

### ***Deadlines and Extensions under Current Law and the Bill for Projects Approved between July 1, 2006 and July 1, 2009***

<i>Deadlines</i>		
<i>Land Use Approval</i>	<i>Current Law (CGS §)</i>	<i>Bill (§)</i>
Residential site plans for projects with 400 or more units	Within 10 years after approval (CGS § 8-3 (j))	No change
Business site plans for projects with at least 400,000 square feet	Between five and 10 years after approval (CGS § 8-3 (j))	No change
Other site plans	Within five years of approval (CGS § 8-3 (i))	Not less than six years after approval (§ 1)
Subdivisions plans for 400 or more dwelling units	Within 10 years of approval (CGS § 8-26g)	11 years after approval (§ 4)
Other subdivisions	Within five years of approval (CGS § 8-26c (a))	Within six years of approval (§ 2)
Wetlands permits for site plans and subdivisions	Permit expires five years after approval (CGS § 22a-42a (d)(2))	Permits expire within six years of approval (§ 4)
Other wetlands	Permit expires between two and five years after approval permits (CGS § 22a-42a (d)(2))	
<i>Extensions</i>		
<i>Land Use Approval</i>	<i>Current Law</i>	<i>Bill</i>
Residential site plans for projects with 400 or more units	No extensions (CGS § 8-3 (j))	No change
Business site plans for projects with	Up to 10 years from approval if the	No change

at least 400,000 square feet	initial deadline was less than 10 years (CGS § 8-3 (j))	
Other site plans	Up to 10 years from approval (CGS § 8-3 (i))	Up to 11 years from approval (§ 1)
Subdivision plans for 400 or more dwelling units	No extensions (CGS § 8-26g)	No change
Other subdivisions	Up to 10 years from approval (CGS § 8-26c (b))	Up to 11 years from approval (§ 2)
Wetlands permits for site plans and subdivisions	Permit expiration date may be extended up to 10 years from approval (CGS § 22a-42a (d)(2))	Permit expiration date may be extended up to 11 years from approval (§ 3)
Other wetlands permits		

Public Act 09-32

HB 5792

*Efficiency Standards for Residential Automatic Law Sprinkler Systems*

Effective: October 1, 2009

**SUMMARY:**

Current law requires any commercial enterprise or state agency that when installing automatic lawn sprinkler systems they be equipped with a rain sensor device or override switch.

This bill expands the mandate for installing cut-off switches on automatic lawn sprinklers; requiring any automatic lawn sprinkler that was installed on residential property on or after July 1, 2010 be equipped with a rain sensor or device that automatically overrides the system when enough rainfall has occurred.

Public Act 09-184

HB 5821

*Economic Development Projects, In-state Micro Businesses and the Standard Wage*

Effective: July 1, 2009, except for that the authorization regarding state-licensed engineers takes effect October 1, 2009.

## **SUMMARY:**

This bill allows state-licensed engineers to certify that economic development projects comply with all state permitting requirements. It specifies the professional criteria an engineer must meet before he or she can certify a project. But it does not indicate if the agency funding the project, the project's developer, or the agency issuing the permit must approve the engineer. Nor does it state if the permitting agency must issue the permit when the engineer certifies compliance.

The bill authorizes a maximum 10% bid preference for businesses that purchase goods or services from a business whose gross revenue in the most recent fiscal year does not exceed \$ 3 million (i. e. , "micro businesses"). The administrative services commissioner may grant the preference when determining the lowest qualified bidder. Current law authorizes the same preference for businesses selling specific types of products. It also requires state agencies to set aside contracts for exclusive bidding by small and minority-owned businesses.

Lastly, the bill amends sHB 6502, which requires among other things, a business taking over a state building service contract to retain the people hired under the prior contract for at least 90 days. Current law imposes a similar requirement on businesses taking over a food and beverage service contract at Bradley International Airport from another business. The bill exempts Bradley food and beverage contracts from sHB 6502's requirement.

\*House Amendment "A" makes a conforming technical change.

\*House Amendment "B" adds the 10% bid preference for businesses purchasing goods or services from micro businesses.

\*House Amendment "C" adds the exemption regarding food and beverage service contracts at Bradley.

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Special Act 09-3

HB 5841

*Concerning a Uniform Reporting Form for Preschool and Child Care Programs*

Effective: Upon passage

**SUMMARY:**

Not later than January 1, 2010, the Commissioner of Social Services, in collaboration with the Commissioners of Education and Public Health, shall develop, and implement the use of, a single form for providers of preschool and child care services to report information necessary to receive state funding.

**REQUIRED ACTION:** Collaborate with DSS, SDE on form for providers.

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Public Act 09-190

HB 5861

*Processing of Municipal Applications for State Permits*

Effective: October 1, 2009

**SUMMARY:**

This bill requires the environmental protection (DEP), public health (DPH), and transportation (DOT) commissioners and the State Traffic Commission, within 60 days after receiving a formal petition, application, or request for a permit from a municipality that must be submitted to these officials, to conduct a preliminary review solely to determine whether the submission is acceptable for filing. The official must notify the municipality of the results of the review. The bill does not preclude the officials from requesting additional information after sending this notice. The officials must do their review within available appropriations. The bill takes priority over laws requiring other procedures.

\*House Amendment "A" eliminates provisions in the original bill that (1) required the officials to notify the municipality of any deficiencies in its submission and (2) deemed a submission to be complete if the officials failed to respond to the municipality by the deadline. It explicitly allows the officials to request additional information. It requires all the agencies, not just DEP and DPH, to act within available appropriations and makes minor changes.

**BACKGROUND*****Legislative History***

The House referred the bill (File 322) to the Environment Committee, which reported it favorably, and the Appropriations Committee, which added the requirement that DEP and DPH act within available appropriations.

**REQUIRED ACTION** : When a petition, application, or request is received from a municipality pursuant to title 19a of the general statutes, DPH is required to respond to the applicant within 60 days with notice of whether or not the application is acceptable for filing. The Drinking Water Section intends to create a form that will be used for all applications for this purpose.

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Special Act 09-9

HB 6087

*Authorizing the University of Connecticut to Receive and Treat Sewage from the Town of Mansfield*

Effective: Upon passage

**SUMMARY:**

The Board of Trustees of The University of Connecticut may enter into an agreement with the town of Mansfield to receive and treat sewage from the Four Corners area of said town. The board of trustees may grant easements over land owned by the university for the purpose of constructing a sewer system to convey the sewage from the Four Corners area to the sewer collection system of the university.

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Public Act 09-235

HB 6097

*Act Concerning Brownfields Development Projects*

Effective: October 1, 2009, except for the floodplains, Transfer Act, and municipal inspection provisions, which are effective upon passage, and the municipal liability protections, innocent third party status, and reimbursement provisions, which are effective July 1, 2009.

**SUMMARY:**

This bill makes many changes affecting the regulatory framework for identifying, investigating, remediating, and developing contaminated property (brownfields). It expands the protections from liability for

municipalities when they take various steps to promote brownfield remediation. These steps include entering and inspecting property and acquiring and conveying it to other parties.

The bill makes it easier for parties acquiring a brownfield to recover investigation and remediation costs from those responsible for contaminating the property. It does so by reducing the criteria for obtaining recovery and establishing procedures and deadlines for starting recovery actions. The procedures include allowing the responsible parties to participate in the investigation and remediation.

The bill establishes a program protecting brownfield developers from liability for contamination that escapes from a brownfield before they acquired it. The program is open to developers who agree to remediate the brownfield according to state standards. The bill also creates a regulatory mechanism allowing developers to remediate the soil and use the property while conducting long-term groundwater monitoring and remediation. It also allows any party, rather than just the owner or a municipality, to complete an environmental condition assessment form.

Lastly, the bill reduces the regulatory criteria state agencies must meet when developing contaminated mill sites in floodplains. It also requires state agencies and quasi-public agencies to provide for the use of green remediation technologies when soliciting bids, requesting proposals, or negotiating contracts for remediating brownfields.

\*House Amendment "A" establishes deadlines and procedures for recovering investigation and remediation costs, expands the range of municipal entities exempted from the transfer act, creates the floodplain exemption for mill projects, expands liability protections for parties acquiring brownfields from municipalities, extends innocent third party status to more municipal entities, and expands liability protections for municipalities inspecting contaminated property. It also adds provisions (1) specifying the local agencies and organizations allowed to acquire and convey property, (2) establishing the Abandoned Brownfield Cleanup Program, (3) authorizing interim verifications for ongoing groundwater remediation, (4) allowing any party to prepare environmental site assessment forms, and (5) authorizing state brownfield remediation contracts to provide for the use of green remediation technologies. Lastly, the amendment eliminates provisions making Connecticut Development Authority's Tax Incremental

Financing Program permanent and limiting the scope of work under a covenant not to sue.

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Public Act 09-192

HB 6284

*Green Building Standards and Energy Efficiency Requirements for Commercial and Residential Buildings*

Effective: Upon Passage

**SUMMARY:**

This bill delays the date when “green building” standards take effect and narrows their scope. It requires the state building inspector and Codes and Standards Committee to establish the threshold size for buildings subject to the standards. Under current law, the standards apply to certain new construction costing \$ 5 million or more and renovations costing \$ 2 million or more.

The bill delays and modifies the requirement that the state building inspector and Codes and Standards Committee revise the State Building Code with regard to energy efficiency standards.

The bill also increases the membership of the Codes and Standards Committee, from 17 to 18, by adding a member with expertise in matters relating to energy efficiency.

\*House Amendment “A” (1) modifies the requirement pertaining to revisions of the state building code and energy efficiency standards, (2) specifies that the bill cannot be construed to impose new requirements on state buildings subject to “green building standards,” (3) adds the Codes and Standards Committee member, (4) excludes a provision that the building code revision include a method for demonstrating compliance at the time of application for a building permit, and (5) makes a technical change.

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Public Act 09-81

HB 6496

Green Cleaning Products in Schools

Effective: October 1, 2009

**SUMMARY:**

By July 1, 2011, this bill requires local and regional school boards to implement a green cleaning program to clean and maintain their schools. The program must provide for procurement and proper use of environmentally preferable cleaning products in schools. The bill requires school districts to use cleaning products inside their schools that (1) meet guidelines or standards set by a national or international certification program approved by the Department of Administrative Services (DAS) in consultation with the environmental protection commissioner and (2) as far as possible, minimize potential harmful effects on human health and the environment.

School districts must provide an annual written statement notifying staff and, if they request it, parents or guardians of enrolled students of the green cleaning program. Districts must publish notice of the program on the board of education's and each school's website or, if there is no website, publicize it in another way. They must also notify parents or guardians of transfer students and newly hired staff about the program.

The bill expands the existing biennial report each school district must make to the education commissioner on the condition of its school facilities and the implementation of its indoor air quality program in those facilities to also cover implementation of the green cleaning program in each school. By April 1, 2010, it requires the State Department of Education, in consultation with the Department of Public Health, to change its school facilities survey form to include questions on phasing in green cleaning programs at schools. The district must post the report information on the school board's and each school's website, or, if there is no website, publicize in another way.

Finally, the bill requires districts to post on the board of education and school websites the results of any required evaluations and inspections of a school building's indoor air quality. By law, such an inspection is required before January 1, 2008 and every five years thereafter for any school building that is built, extended, renovated, or replaced on or after January 1, 2003. The website posting requirement is in addition to

existing requirements that the results of the evaluation be available for public inspection at a regularly scheduled board of education meeting.

\*House Amendment "A" eliminates requirements in the original bill (File 513) that (1) the environmentally preferable cleaning products meet the standards of a certified independent third party that meets specified criteria; (2) DAS develop guidelines for the green cleaning programs and provide a list of vendors who sell them and provide training to users; (3) school facility managers, custodians, and indoor air quality committees be trained in best cleaning management practices and complete a refresher course every five years; and (4) school district mail a green cleaning program notice to each parent and guardian or student annually. It also alters and clarifies program implementation deadlines, allows a school district to publish the program notices in another way if the school board and schools have no website, and adds a requirement that districts provide the green cleaning program notice to parents and guardians of students who transfer to the district and staff members who are hired during the school year.

\*House Amendment "B" changes the date by which school districts must start providing the annual written green cleaning statement from October 1, 2011 to October 1, 2010 and requires that school districts provide the notice to parents and guardians only if they request it.

## **ENVIRONMENTALLY PREFERABLE CLEANING PRODUCTS**

Under the bill, an environmentally preferable cleaning product must be certified as such by a DAS-approved national or international certification program. The term "environmentally preferable cleaning product" includes general purpose, bathroom, glass, and carpet cleaners; hand cleaners and soaps; and floor finishes and strippers. It excludes antimicrobial products regulated under the Federal Insecticide, Fungicide and Rodenticide Act, such as disinfectants, disinfecting cleaners, and sanitizers. It also excludes products (1) for which no DAS-approved certification program has established a guideline or environmental standard, (2) that fall outside the scope of such guidelines or standards, or (3) that are otherwise excluded under such guidelines or standards.

## **GREEN CLEANING PROGRAM NOTICE**

Every year, starting by October 1, 2010, the bill requires each school district to give school staff and, if they request it, students' parents and

guardians a written statement about its green cleaning policy. It requires the “notice” (presumably the written statement and the notice are the same) to include:

1. the names and types of environmentally preferable cleaning products used in the schools and where in the buildings they are applied;
2. the schedule for applying the products; and
3. the name of the school administrator or designee whom the parent, guardian, or student may contact for more information.

The notice must also contain the following statement: “No parent, guardian, teacher, or staff member may bring into the school facility any consumer product which is intended to clean, deodorize, sanitize or disinfect.”

Districts must provide the notice to parents and guardians of students who transfer to a school and to any staff hired during the school year. They must also post it on the board of education's and each school's website or, if there is no website, make it publicly available in another way.

**REQUIRED ACTION:** Provide information to SDE to amend the school survey procedures to include questions regarding the phase-in of green cleaning supplies.

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Public Act 09-183

HB 6502

*The Standard Wage for Certain Connecticut Workers*

Effective: July 1, 2009

**SUMMARY:**

This bill creates a new method for determining the hourly wage and benefits for employees under the standard wage law, which governs compensation for employees of private contractors who do building and property maintenance, property management, and food service work in state buildings. Under the bill, such employees will receive the same prevailing wage rates and prevailing benefits as employees working

under the union agreement covering the same type of work for the largest number of hourly nonsupervisory employees, as long as it covers at least 500 employees, in Hartford County.

This ties the state pay and benefits for standard wage workers to those provided under the private sector union contract that meets the bill's criteria. If there is no private sector contract that meets the bill's criteria, then the law's current standard wage rate will apply.

The new wages and benefits affect standard wage contract workers hired after July 1, 2009. Those already working for standard wage employers on or before July 1, 2009 will be paid an hourly wage based on the current standard wage law, but after July 1, 2009 their benefits will be the same as those working under a Hartford County union contract for the same type of work.

The bill requires a new contractor that takes over an existing building service to keep the employees from the predecessor contract for at least 90 days after the date it begins service under the successor contract and permits it to fire them only for cause. This provision does not apply to employees who worked less than 15 hours a week or who were employed at the worksite for less than 60 days.

If an employee performs satisfactorily during the 90-day period, the successor contractor must offer him or her continued employment for the contract's duration under the terms and conditions of the successor contractor or as required by law.

The bill excludes people with disabilities or disadvantaged people working in the janitorial work pilot program under contracts with no more than four full-time workers from the provision requiring employees to be hired by a new contractor taking over a predecessor contract. This appears to apply whether the people under the janitorial pilot program work for the new contractor taking over a predecessor contract or for the predecessor contractor when the new contractor takes over. The bill also exempts employees under the janitorial work pilot program from the requirement that the standard wage be considered their minimum wage.

## Concerning Environmental Health

Effective: October 1, 2009

### **SUMMARY:**

This bill requires exclusive service area providers (ESAPs) to confirm in writing that they (1) have received the applications for public water supply certificates of need and public convenience submitted to the Public Health (DPH) and Public Utility Control (DPUC) departments and (2) are prepared to assume responsibility for the system. It requires the departments, when deciding whether to issue a certificate, to consider whether the system's owner has the financial, managerial, and technical resources to operate it efficiently and reliably and provide continuous, adequate service to consumers.

It requires water company supply plans to include a brief summary of the company's underground infrastructure replacement practices. It lengthens, to between six and nine years, from between three to five years, the time between required plan revisions, in most cases.

The bill extends the time for DPH to establish and define discharge categories for certain alternative on-site sewage treatment systems.

Finally, it updates DPH's responsibilities concerning safe levels of radon.

\*House Amendment "A" (1) requires the ESAP's written confirmation concerning the receipt of the applications and assumption of responsibility for the system; (2) requires plan revisions between six and nine years; (3) adds the provision on alternative on-site sewage treatment systems; (4) adds the provisions on radon; and (5) makes technical changes.

### **CERTIFICATES OF NEED AND PUBLIC NECESSITY**

By law, anyone who owns, operates, maintains, or manages a water system that supplies 15 or more service connections or 25 or more people for at least 60 days a year is a water company. This definition can apply to residential communities, professional offices, and youth camps, for example. Any water company that wants to construct or expand a water supply system that serves 25 or more residents must obtain a certificate of need and public necessity from the Public Health (DPH)

and Public Utility Control departments. Once a system is constructed, an exclusive service area provider (ESAP) must own and operate it.

Under current law, a water company's application for a certificate must include its plans and its agreement with the ESAP detailing the terms and conditions for the construction or expansion. The bill specifies that this is necessary only when an ESAP has been determined. It also requires that, when an ESAP has been determined, the applicant submit its signed ownership agreement with the ESAP.

The bill also requires ESAPs to confirm in writing that they (1) have received the applications for public water supply certificates of public convenience and necessity submitted to the DPH and DPUC and (2) are prepared to assume responsibility for the system subject to the terms and conditions of the ownership agreement. The ESAP's written confirmation must be on forms prescribed by the departments.

Finally, it requires the departments, when deciding whether to issue a certificate, to consider whether the person that will own the system (the ESAP or the water company, if no ESAP is determined) has the financial, managerial, and technical resources to operate the system efficiently and reliably and provide continuous, adequate service to the system's consumers. The same requirement already applies to applicants for certificates of need and public necessity for systems serving 25 or more people, but not 25 or more residents.

## **WATER SUPPLY PLAN REVISIONS**

By law, water companies supplying water to 1,000 or more people or 250 or more consumers (and any other water companies at DPH's request) must file a water supply plan that, among other elements, analyses future needs, assesses alternative supply sources, recommends new system development, and evaluates water source protection. The bill adds a new element that plans must include: a brief summary of the company's underground infrastructure replacement practices. These may include current and future infrastructure needs, methods for identifying and ranking rehabilitation and replacement projects, and funding needs.

Once approved, current law requires these plans to be revised every three to five years or as DPH or the water company determines. The bill requires a revision every six to nine years after the date of the most recently approved plan. But, if a water company fails to meet public

drinking water supply and quantity obligations, it must file plan revisions six years after the date of the most recently approved plan, unless DPH requests otherwise. Beginning October 1, 2009, the bill requires that upon approval of a water supply plan, any subsequent revisions must minimally have updates to the elements described above that have changed since the date of the most recently approved plan, unless DPH has not otherwise requested an entire water supply plan submission.

## **ALTERNATIVE ON-SITE SEWAGE SYSTEMS**

The law required the DPH commissioner, by December 31, 2008, to establish and define discharge categories for alternative on-site sewage treatment systems that have a daily capacity of 5,000 gallons or less. The law gives the DPH commissioner jurisdiction over these systems once he has done so and requires him to establish minimum requirements for the systems. The bill extends the time for the commissioner to establish and define these discharge categories by removing the deadline.

## **RADON**

Current law requires DPH to adopt regulations establishing safe levels of radon in potable water. The bill instead requires DPH to adopt regulations concerning radon in drinking water consistent with federal drinking water regulations.

By law, DPH must adopt regulations establishing acceptable levels of radon in ambient air and drinking water in schools. The bill instead requires DPH to adopt regulations establishing radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated radon gas levels when detected in public schools.

Before January 1, 2008 and every five years afterward, the law requires local and regional boards of education to provide for a uniform inspection and evaluation program for the indoor air quality for every school building constructed, extended, renovated, or replaced on or after January 1, 2003. Among other things, the program must include a review, inspection, or evaluation of radon levels in the air and water. Under the bill, only radon levels in the air must be inspected and evaluated.

## **BACKGROUND**

## ***Designating ESAPs***

Water Utility Control Committees convened by DPH designate exclusive service areas, which are the approved by the DPH commissioner. An exclusive service area is an area where public water is supplied by one system. Currently, four committees have been convened covering about 110 towns, mostly in central and southeastern portions of the state and the Housatonic region.

**REQUIRED ACTION**: In Section 1 additional requirements are needed to be fulfilled by an applicant for a Certificate of Public Convenience and Necessity for a proposed community public water system. These requirements will be included in the Drinking water Section's review of those applications. The requirements are that where an exclusive service area (ESA) provider has been determined the applicant must submit an ownership agreement between the applicant and ESA provider. The application must also contain a written confirmation from the ESA provider that ESA provider has received the application and is prepared to assume responsibility for the system subject to the terms and conditions of the ownership agreement. The Drinking Water Section will work with the Department of Public Utility Control to include the requirements within the application.

In Section 2 Water Supply Plans must include an underground infrastructure. Systems with a plan approved after October 1, 2009 can submit revisions to their plan that minimally consists of updates to those elements of the plan that have changed since prior approval unless otherwise requested by the Commissioner.

In Section 3 DPH will fulfill other requirements of CGS Section 19a-35a when funds are appropriated in accordance with the fiscal note DPH filed at the time the alternative treatment (AT) systems was passed.

Section 4 removes the requirement that DPH determines what the safe level of radon in potable water is and adds the requirement that DPH regulations concerning radon in drinking water are consistent with the Safe Drinking Water Act.

Section 5 requires DPH to establish radon measurement requirements and procedures for measuring radon in indoor air.

*Simplifying Procedures for Early Childcare and Early Childhood Education Facilities*

Effective: Upon Passage

The Departments of Social Services, Education and Public Health shall conduct a joint study of the requirements and procedures related to early childcare and early childhood education to simplify procedures for caregivers. The study shall include an examination of the regulations and other requirements of the departments that apply to caregivers of young children. The departments shall (1) identify existing requirements and procedures that are duplicative or unnecessary, and (2) make recommendations for simplifying requirements and procedures for caregivers.

Not later than January 1, 2010, the Commissioners of Social Services, Education and Public Health shall submit a joint report of the departments' findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to human services, education and public health, in accordance with the provisions of section 11-4a of the general statutes.

Not later than January 1, 2010, the Departments of Education and Public Health shall jointly develop and implement a single standard for determining if an individual has obtained twelve or more credits in early childhood education or child development for the purpose of: (1) Qualification as a head teacher of a child day care center licensed by the Department of Public Health pursuant to section 19a-80 of the general statutes, or (2) qualification as a teacher in a program receiving school readiness funds from the Department of Education.

**REQUIRED ACTION**: A representative of the Department will need to meet periodically with representatives of DSS and SDE to examine the requirements placed on child care providers by each of the departments and identify duplicative or unnecessary requirements. The representatives shall, no later than 1/1/10, submit a joint report of the departments' findings and recommendations for simplifying the requirements and procedures. A DPH representative shall also meet with a representative of SDE to develop and implement a single standard for determining whether an individual has obtained 12 or more credits in early childhood education or child development.

*Banning Bisphenol-a in Children's Products and Food Products*

Effective: October 1, 2011

**SUMMARY:**

The bill bans, starting October 1, 2011, the sale, manufacture, or distribution in the state of:

1. infant formula and baby food stored in containers made with bisphenol-A and
2. reusable food and beverage containers made with bisphenol-A.

It authorizes the Department of Consumer Protection (DCP) to enforce the ban within available appropriations.

\*House Amendment "A" eliminates a provision barring manufacturers from substituting for bisphenol-A other substances that are or may be carcinogenic in the manufacture of a product.

\*Senate Amendment "A" eliminates a warning label requirement.

**INFANT FORMULA AND BABY FOOD IN CONTAINERS MADE WITH BISPHENOL-A**

The bill bans, starting October 1, 2011, anyone from manufacturing, selling, or offering for sale or distribution in Connecticut infant formula or baby food stored in a plastic container, can, or jar that contains bisphenol-A. It allows people who can prove they purchased these containers before October 1, 2011, to sell or distribute their existing inventory until October 1, 2012, if they can show they purchased about the same number of containers before October 1, 2011 that they purchased in the same period the previous year.

The bill defines "infant formula" as a commercially available milk- or soy-based powder, concentrated liquid, or ready-to-feed substitute for human breast milk, intended for infant consumption. It defines "baby food" as a commercially available prepared solid food consisting of a soft paste or an easily chewed food intended for consumption by children age two or younger.

## REUSABLE FOOD AND BEVERAGE CONTAINERS MADE WITH BISPHENOL-A

Under the bill, a reusable food or beverage container is a receptacle for storing food or beverages, including baby bottles, spill-proof cups, sports bottles, and thermoses, but excluding food and beverage containers intended for disposal after initial use.

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Public Act 09-112

SB 03 (VETOED)

*Prohibiting the Acquisition or Use of Certain Parcels of Land as Ash Residue Disposal Areas and Concerning the Operation of a Food-to-Energy Plant*

Effective: Upon passage

### SUMMARY:

This bill prohibits the Connecticut Resources Recovery Authority (CRRA) or any other person or entity, regardless of any law to the contrary, from condemning, buying, leasing, accepting, taking title to, using, or otherwise acquiring certain parcels of land in the towns of Franklin and Windham for use as an ash residue disposal site.

It prohibits the (1) Connecticut Siting Council from issuing a certificate of environmental compatibility and environmental need and (2) Department of Environmental Protection (DEP) commissioner from issuing a solid waste permit to build or operate a food waste-to-energy plant in a distressed municipality of more than 100,000 people where there is a liquefied natural gas storage facility of between 10 million and 15 million gallons and a combustion turbine power plant of less than 100 megawatts, if the proposed waste-to-energy plant would be located within two miles of one or more university regional campuses, hospitals, performing arts centers, churches, and schools, including magnet schools. It appears that Waterbury is the only municipality that meets these criteria.

\*Senate Amendment "A" prohibits other people or entities, in addition to CRRA, from acquiring certain property in Windham and Franklin for use as an ash residue disposal site.

\*Senate Amendment "B" prohibits the Siting Council and DEP commissioner from issuing a certificate or permit, respectively, to build or operate a food waste-to-energy plant in a municipality where certain conditions exist (apparently Waterbury).

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Public Act 09-229

SB 891

*Modernizing Connecticut Fertilizer Law*

Effective: July 1, 2009, except (1) upon passage for the milk producer grant program and (2) October 1, 2009 for provisions concerning adulterated milk.

**SUMMARY:**

This bill updates the laws regulating fertilizer, changes the law concerning adulterated milk, and creates a grant program for dairy farmers ("milk producers").

The bill updates fertilizer law by replacing current law's provisions, which are based on a 1965 recommended model law from the Association of American Plant Food Control Officials (AAPFCO), with the most recent AAPFCO recommended version.

The bill supersedes any inconsistent or conflicting special acts municipal ordinances, or regulations. It prohibits municipalities from enacting or attempting to enforce any ordinance or regulation concerning registration, packaging, labeling, sale, storage, distribution, use, or application of a fertilizer. It explicitly extends the Department of Agriculture (DOAG) commissioner's enforcement powers to regulations he adopts and allows anyone aggrieved them to appeal to Superior Court.

The bill creates an account to assist milk producers and funds it by temporarily increasing from the bill's effective date until July 1, 2011 the fee people pay, from \$ 30 to \$ 40, when filing documents with town clerks. The bill accordingly temporarily decreases portion of funds for certain programs three entities receive from this fee and increases the amount the DOAG receives. It requires DOAG to use the majority of the funds for the milk producer grant program.

The bill removes nonprofit agriculture organizations as eligible for DOAG's farm transition grant program. By law, the program provides

matching grants for diversification of existing farm operations, transitioning to value added agricultural production and sales, and developing farmers' markets and other venues in which a majority of products sold are grown in the state. It adds these entities to those eligible for DOAG's farm viability matching grant program. Under current law, farm viability matching grants may be used for (1) local capital projects that foster agricultural viability, including, processing facilities and farmers' markets, and (2) the development and implementation of agriculturally friendly land use regulations and local farmland protection strategies that sustain and promote local agriculture.

The bill also adds to the viability matching grant's purposes the development of new marketing programs and venues through or in which a majority of products sold are state grown.

This bill explicitly prohibits selling, offering to sell, bartering, or exchanging adulterated milk, milk products, or cheese (i. e. , dairy products), and related activities. A first violation is an infraction and a second violation within one year is a class A misdemeanor. It exempts production of dairy products for personal consumption or consumption by immediate family members from its prohibitions.

The bill eliminates the DOAG commissioner's option to adopt regulations that incorporate by reference the federal Pasteurized Milk Ordinance. It requires instead that all milk dealers processing, handling, storing, distributing, transporting, selling, offering for sale, bartering, or exchanging any dairy product comply with the sanitation, handling, storage, and processing requirements of relevant state milk and milk product laws and regulations.

It defines "adulterated" and "misbranded" dairy products and makes technical changes.

It makes numerous minor, conforming, and technical changes.

\*Senate Amendment "A" makes changes to the update of the fertilizer law and adds the provisions concerning adulterated milk.

\*Senate Amendment "B" creates and funds the milk producer grant program.

## **ADULTERATED MILK PROHIBITIONS AND VIOLATIONS**

The bill explicitly prohibits adulterating dairy products and selling, offering to sell, bartering, or exchanging them. It also prohibits:

1. selling, offering for sale, bartering, exchanging, manufacturing, distributing, or processing such products from an unlicensed facility or
2. selling, offering for sale, distributing, or offering for barter or exchange milk for pasteurization, retail raw milk, or retail raw milk cheese from an unregistered dairy farm. (By law, dairy product facilities must be licensed by, and dairy farms must be registered with, DOAG. )

Under the bill, violators commit (1) an infraction for the first violation and (2) a class A misdemeanor for the second or subsequent violation within a year of the first. (An infraction is not a crime but subjects the violator to a fee; a class A misdemeanor is punishable by up to one year in prison, a \$ 2,000 fine, or both. ) The bill specifies that it does not prevent the DOAG commissioner from seeking any other remedy the law provides.

By law, the DOAG commissioner may tag or otherwise mark a dairy product that it is suspected of being adulterated or misbranded. Violators are subject to an administrative civil penalty.

## **ADULTERATED AND MISBRANDED DAIRY PRODUCTS**

The bill defines “adulterated” as any milk, milk product, retail raw milk, or cheese that:

1. bears or contains any poisonous or deleterious substance, which may render the dairy product injurious to health, provided, if the substance is not an added substance, the dairy product is not considered adulterated if the quantity of the substance would not ordinarily render it injurious to health;
2. bears or contains any added poisonous or deleterious substance that is unsafe;
3. consists in whole or part of any diseased, contaminated, filthy, putrid, or decomposed substance or is otherwise unfit for food;

4. has been produced, prepared, packed, or held under insanitary conditions whereby it may have become contaminated with filth or rendered diseased, unwholesome, or injurious to health; or

5. has packaging or a container which is composed in whole or part of any poisonous or deleterious substance, which may render the contents injurious to health.

The bill defines “misbranded” as the use of any label, written or printed advertising, or graphic upon or accompanying a product or container of milk, milk products, or cheese, including, signs, electronic displays, electronic communication, placards, or other means of communication intended to provide information to consumers, which is false or misleading or which violates any applicable municipal, state, or federal labeling requirement.

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Public Act 09-56

SB 1020

*Pesticide Applications at Child Day Care Centers and Schools*

Effective: October 1, 2009, except for the extension to 2010 of the lawn care pesticides exception, which is effective July 1, 2009

**SUMMARY:**

This bill (1) eliminates restrictions on when applications of pesticides, other than lawn care pesticides, can be made on the grounds of day care centers; (2) broadens, with conditions, when pesticide applications are allowed in day care centers; (3) establishes who may apply pesticide inside centers; and (4) requires day care center licensees or their designees to determine that emergency pesticide applications are necessary in or on the grounds of these facilities. The bill defines “day care center” as a child day care center, group day care home, or family day care home that provides child day care services.

The bill also establishes pesticide application notification requirements for day care center licensees to inform parents and guardians of children in their care who have requested notice. By law, applications on day care center buildings and grounds cannot use a pesticide the U. S. Environmental Protection Agency (EPA) considers a restricted use pesticide, and no child enrolled in a day care center or home may enter

an area where a pesticide has been applied until it is safe to do so according to the provisions on the pesticide label.

Current law prohibits the application of lawn care pesticides on the grounds of any public or private school with students up to grade eight, except in emergencies to eliminate human health threats. But it allows, until July 1, 2009, the lawn care pesticide application according to an integrated pest management plan on these schools' playing fields and playgrounds. The bill extends this exception to the ban one year, to July 1, 2010.

## **PESTICIDE APPLICATION AT DAY CARE CENTERS**

### ***Inside Application***

Current law prohibits anyone from applying pesticides during regular business hours in any building of any child day care center, group day care home, or family day care home, except in emergencies. The bill allows pesticides applications in a day care building regardless of whether there is an emergency and without restrictions on the time of day. But, under such non-emergency situations, it permits only "certified pesticide applicators" to apply the pesticide. Under the bill, a "certified pesticide applicator" is one with (1) supervisory certification or (2) operational certification who is under the direct supervision of a pesticide applicator with supervisory certification, according to law.

As under current law, anyone may apply pesticides in such buildings to eliminate immediate threats to public health, which the bill specifies includes those posed by mosquitoes, ticks, or stinging insects. In such emergencies, the bill requires the day care licensee or his or her designee to determine (1) an emergency application is necessary and (2) it is impractical to obtain a certified pesticide applicator's services.

### ***Outside and Lawn Care Pesticide Application***

The bill eliminates the prohibition against anyone applying pesticides on the grounds of any day care center or group day care or family day care home during regular business hours, except in an emergency. By law, a pesticide is a fungicide used on plants, an insecticide, a herbicide, or a rodenticide. It does not include a sanitizer, disinfectant, antimicrobial agent, or a pesticide bait.

Current law prohibits anyone from applying lawn care pesticide on the grounds of any child day care center or group day care home, except in an emergency to eliminate an immediate threat to human health, including from mosquitoes, ticks, and stinging insects. The bill specifies that emergency applications of lawn care pesticides on day care facility grounds (which also include family day care homes) require that the day care licensee or his or her designee determines an emergency application is needed. The bill excludes family day care homes located on land not owned or under the control of the licensee from this requirement.

By law, “a lawn care pesticide” is a U. S. EPA registered pesticide that is labeled in accordance with the federal Insecticide, Fungicide, and Rodenticide Act for use in lawn, garden, and ornamental sites or areas.

## **NOTICE REQUIREMENTS**

The bill requires day care licensees, starting October 1, 2009, to notify, at least 24 hours before applying pesticides in or on a facility's grounds, parents and guardians of children in their care who have requested such notice. They must do so within existing budgetary resources. It exempts emergency applications from this requirement, requiring the licensee or designee in these cases to notify parents or guardians as soon as practicable.

The notice must include (1) the name of the pesticide's active ingredient, (2) the target pest, (3) the application's location on the property, and (4) the date or proposed date of the application. The day care provider must keep a record of each pesticide application at the facility for five years.

## **BACKGROUND**

### ***Child Day Care Services***

By law, child day care services include a child day care center, which provides care to 12 or more children; a group day care home, which provides care to between seven and 12 children; and a family day care home, which provides care to six or fewer children.

### ***Integrated Pest Management Plan (IPM)***

IPM is the use of all available pest control techniques, including judicious use of pesticides, when warranted, to maintain a pest population at or below an acceptable level, while decreasing the use of pesticides.

**REQUIRED ACTION** : CBR should post information under “What’s New” on the Child Day care Licensing web page as part of legislative updates. CBR staff will follow up on complaints concerning pesticide applications in child day care programs.

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Public Act 09-30

SB 1021

*Notification of Contaminants in Drinking Water*

Effective: Upon Passage

**SUMMARY:**

This bill requires the public health commissioner, no later than five business days after receiving notice that a public water system violates U.S. Environmental Protection Agency national primary drinking water standards, to notify, either in writing or electronically, the chief elected official of (1) the municipality where the public water system is located and (2) any municipality it serves. The bill does not define public water system, but under the Public Health Code a “public water system” is any water company supplying water to 15 or more consumers or 25 or more people (see BACKGROUND).

\*House Amendment “A” replaces the original bill, adding the five business day deadline and eliminating a reference to community and non-community water systems.

**BACKGROUND**

***National Primary Drinking Water Regulations***

National Primary Drinking Water regulations are legally enforceable standards that apply to public water systems. Primary standards limit the levels of contaminants in drinking water.

***Public Water System***

In addition to the Public Health Code definition (Conn. Agency Regulations § 19-13-B102 (51)), the statutes contain several definitions of public water systems. By law, a public water system variously means a:

1. private, municipal or regional utility supplying water to 15 or more service connections or 25 or more people (CGS § 25-33d);
2. corporation, company, municipality, political subdivision, association, joint stock association, partnership or person, or lessee thereof, owning, maintaining, operating, managing, or controlling any pond, lake, reservoir, or distributing plant employed for the purpose of supplying water for general domestic use in any town, city, or borough, or portion thereof, in the state (CGS § 22a-358); and
3. public water system, as defined for the purposes of the federal Safe Drinking Water Act, as amended or superseded (CGS § 22a-475).

**REQUIRED ACTION**: When a public water system is in violation of an EPA primary drinking water standard, the section must notify the CEO of the town where the source of drinking water is located, and the CEO of every town served by such drinking water source. It is expected that this will be done electronically. Inform staff of the new requirement.

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Public Act 09-157

SB 1080 (VETOED)

*Access to Health and Nutritional Information in Restaurants*

Effective: July 1, 2009, except that the provision on authorized agents' inspections takes effect July 1, 2010.

**SUMMARY:**

This bill requires chain restaurants to disclose on their standard printed menus or menu boards total calorie counts for standard menu items. The Department of Public Health (DPH) must adopt regulations incorporating the calorie information requirements into regularly scheduled inspections of such food service establishments.

\*Senate Amendment "A" (1) provides additional definitions; (2) adds the provisions on food item tags, food items intended for more than one individual, reasonable means for determining calorie totals, effect on municipal laws and local zoning, offering of voluntary supplemental information, and trade secrets and proprietary information; and (3) changes some of the provisions in the original bill concerning calorie

disclosure of varieties and flavors of standard menu items and items in a salad bar, buffet, or similar arrangement.

**REQUIRED ACTION** : The Section would be required to develop inspection and enforcement guidelines for enforcement by local health departments, and to amend the Inspection Report (form) for Food Service Establishments. In addition it will be necessary to develop training materials and to provide training for local health departments.

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## **Acts Affecting Multiple Service Branches**

Public Act 09-185

HB 5421

### *Proceedings and Operations of the Department of Children and Families and the Disclosure of Adoption Information*

Effective: October 1, 2009, except the provisions concerning temporary relative placements are effective on passage and the provisions concerning guardianship transfers and mandated reporters are effective July 1, 2009.

#### **SUMMARY:**

This bill requires courts to look for suitable caretaker relatives (related by blood or marriage) in the early stages of cases where children have been, or are at risk of being, removed from their homes due to allegations of abuse or neglect. It allows a parent who is the subject of the abuse or neglect charges to ask the Department of Children and Families (DCF) commissioner to investigate placing the child with relatives and, where practicable, requires the commissioner to report on a relative's suitability at the first court hearing in the case. It establishes court procedures for making placement decisions when a relative seeks custody and creates a rebuttable presumption that placing a child with a relative is in the child's best interests.

#### **§ 504 — ACCESS TO DCF RECORDS**

Currently DCF cannot release information tending to identify a biological parent without the written consent of both parents. Beginning October 1, 2009, the bill allows DCF and adoption agencies to release information if the biological parent whose information is to be disclosed provides written consent. DCF or the adoption agency must first attempt to locate the other biological parent to obtain written consent to

permit disclosure. If he or she cannot be located or does not provide written consent, identification of the consenting parent may be disclosed provided: (a) information concerning the non-consenting parent is not disclosed and (b) the consenting parent signs an affidavit that he or she will not disclose information that identify the non-consenting parent without written consent.

### ***Confidential DCF Records***

In general, DCF cannot disclose information it creates or obtains in connection with its child protection activities or other activities related to a child who is or was in its care or custody or a person it has investigated for child abuse or neglect without (1) obtaining permission from the person who is the subject of the record or an authorized representative or (2) legal authorization to do so without the person's consent. Existing law specifies many entities and officials to whom DCF must disclose records that would otherwise be confidential, in most cases expressly limiting the uses recipients can make of the information. It also lists entities and people with whom DCF may share information when the commissioner or her designee determines this is in the best interests of the person who is the subject of the record.

Anyone who discloses any part of a confidential record is subject to imprisonment for up to one year, a fine of up to \$ 1,000, or both.

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Public Act 09-19

HB 5930

### ***Act Requiring Small Business Impact Analysis for Proposed Regulations***

Effective: October 1, 2009

### **SUMMARY:**

This bill requires any state agency proposing a regulation to identify how it affects small businesses (i. e. , small business impact analysis) and include the analysis as part of the fiscal note it must submit to the Regulations Review Committee. The law already requires agencies to determine if a proposed regulation adversely affects small businesses and, if it does, to consider other less burdensome ways to achieve the regulation's goal (i. e. , regulatory flexibility analysis). The bill raises the threshold for the regulatory flexibility analysis, from fewer than 50 to

fewer than 75 employees. It does not define small business for the small business impact analysis.

Before adopting a regulation, the bill requires agencies to notify the public about how to obtain copies of the small business impact and regulatory flexibility analyses. The agencies must also notify the Commerce Committee about the regulation if they believe it could adversely affect small businesses, and it must help them prepare the flexibility analysis. Agencies must already notify the Department of Economic and Community Development about proposed regulations that could adversely affect small businesses, and the department must help them prepare the analysis.

Under the bill, a proposed regulation does not take effect until the agency submits the regulatory flexibility analysis to the Regulations Review Committee. By law, the regulation does not take effect until the agency gives the committee the original proposed regulation, as approved the attorney general, and 18 copies.

## **SMALL BUSINESS IMPACT ANALYSIS**

### ***Scope***

By law, agencies must prepare and attach a fiscal note to a proposed regulation when they submit it to the Regulations Review Committee. The bill requires agencies to prepare the fiscal note before, rather than after, publishing the public notice. It also requires that the fiscal note include an estimate of the regulation's cost or revenue impact on the state's small businesses, including the (1) estimated number of small businesses that would have to comply with the regulation and (2) how much it would cost them to do so. Costs include reporting, recordkeeping, and administrative costs. The law already requires the agency to include the regulatory flexibility analysis in the fiscal note, which it must also submit to the committee.

### ***Public Notice***

The bill requires agencies to inform the public about how it can obtain copies of the small business impact and regulatory flexibility analyses before adopting a regulation. (The bill contains an incorrect statutory reference regarding the small business impact analyses. ) They must include this information in the notice advising the public of their intent

to adopt regulations. By law, agencies must publish this notice in the *Connecticut Law Journal* at least 30 days before adopting a regulation.

## **REGULATORY FLEXIBILITY ANALYSES**

The law requires agencies to determine if a proposed regulation adversely affects small businesses and, if it does, to prepare a regulatory flexibility analysis to consider ways to minimize the impact and still accomplish the regulation's purpose without compromising public health, safety, and welfare. The bill specifies that the regulatory methods must be consistent with public health, safety, and welfare. And it makes a technical change.

The bill requires agencies to include the regulatory flexibility analysis in the regulation's official record.

By law, agencies do not have to prepare regulatory flexibility analyses for emergency regulations, those indirectly affecting small businesses, or certain other types of regulations.

### ***Small Business Definition***

Under current law, independently owned and operated businesses with fewer than 50 full-time employees or gross sales under \$ 5 million are considered small businesses. The bill increases this threshold to 75 employees. By law, agencies may set a higher full-time employee limit if necessary to meet or address specific small business needs and concerns. The limit cannot exceed the applicable federal standard or 500 employees, whichever is less.

**REQUIRED ACTION**: Will need guidance on how to prepare cost projections. Other sections of DPH will need to analyze this legislation to ascertain if DPH policy pertinent to their Branch need revisions. All branch staff should be made aware of the new requirement.

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Public Act 09-128

HB 6200

### ***The Use of Long-Term Antibiotics for the Treatment of Lyme Disease***

Effective: July 1, 2009

## **SUMMARY:**

Beginning July 1, 2009, this bill allows a licensed physician to prescribe, administer, or dispense long-term antibiotic therapy to a patient for a therapeutic purpose that eliminates the infection or controls the patient's symptoms if (1) a clinical diagnosis is made that the patient has Lyme disease or has symptoms consistent with such a diagnosis and (2) the physician documents the diagnosis and treatment in the patient's medical record.

Also beginning July 1, 2009, the bill prohibits (1) the Department of Public Health from initiating disciplinary action against a physician and (2) the Connecticut Medical Examining Board from taking disciplinary action solely because the physician prescribed, administered, or dispensed long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease. The physician must document the clinical diagnosis and treatment in the patient's record.

The bill specifies that, subject to the limits on discipline of physicians treating Lyme disease established by the bill, it does not limit the ability of the Connecticut Medical Examining Board to take disciplinary action for other reasons against physicians, including entering into a consent order, for violations of existing law concerning their practice of medicine.

\*House Amendment "A" (1) specifies that the physician's prescribing and administering long-term antibiotic therapy must be for therapeutic purposes that eliminates the infection or controls the symptoms; (2) specifies that a Lyme disease determination by a physician must be (a) based on a medical history and physical examination alone or (b) in conjunction with testing supporting the determination; (3) clarifies that the bill allows the Medical Examining Board to take disciplinary action against physicians for other reasons; and (4) makes technical changes.

## **LYME DISEASES DIAGNOSIS AND TREATMENT**

The bill defines "Lyme disease" as the clinical diagnosis, by a state-licensed physician, of the presence in a patient of signs or symptoms compatible with acute infection with *borrelia burgdorferi*; or with late stage or persistent or chronic infection with *borrelia burgdorferi*, or with complications related to such an infection; or such other strains of *borrelia* that beginning July 1, 2009, are recognized by the federal

Centers for Disease Control and Prevention (CDC) as a cause of Lyme disease.

Lyme disease also includes an infection that meets the surveillance criteria of CDC, and other acute and chronic manifestations of such an infection as determined by a physician according to a clinical diagnosis based on medical history and physical examination alone, or in conjunction with testing that provides supportive data for the diagnosis.

“Long-term antibiotic therapy” means administering oral, intramuscular, or intravenous antibiotics, singly or in combination, for periods exceeding four weeks.

**REQUIRED ACTION**: Educate PLIS staff and provider community.

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Public Act 09-77

HB 6264

*State-wide Health Care Facility Planning*

Effective: July 1, 2009

**SUMMARY:**

This bill revises the way the Office of Healthcare Access (OHCA) (1) conducts health care facility utilization studies and (2) develops a state health care facilities plan. It specifies the elements OHCA must examine in each document. It requires OHCA to prepare the utilization study annually and the facilities plan every five years.

**STATE HEALTH CARE FACILITIES PLAN**

The law requires OHCA to create and maintain a statewide health care facilities plan. OHCA must consider this plan and the Public Health Department's state health plan in making certificate of need decisions. The bill requires it to update the existing plan (OHCA has never written a plan) by July 1, 2012 and every five years thereafter. It also requires OHCA to consult with any state agency the commissioner deems appropriate.

Under the bill, the plan may:

1. assess the availability of care in acute care and specialty hospitals, emergency rooms, outpatient surgical centers, clinics, and primary care sites (the bill does not define clinic or primary care);
2. evaluate the unmet needs of people the OHCA commissioner determines are at risk and of populations she determines are vulnerable;
3. project future demand for health care services and the effect technology may have on the demand, capacity, or need for services; and
4. recommend expansion, reduction, or modification of health care facilities.

In developing the plan, OHCA (1) must consider recommendations from any advisory bodies the commissioner establishes and (2) may use recommendations from authoritative organizations that promote best practices or evidence-based research. OHCA must consult with hospital representatives to develop a process that encourages hospitals to incorporate OHCA's plan into their long-range planning. Finally, OHCA must help appropriate state agencies communicate about innovations or changes that may affect future health planning.

The bill eliminates the requirement for OHCA, in creating the facilities plan, to

1. determine the availability of long-term and home health care in public and private institutions and community-based diagnostic and treatment facilities,
2. determine the scope of these services, and
3. anticipate future needs for these services and facilities.

**REQUIRED ACTION** : The Planning Branch will need to work with OHCA to develop the OHCA Plan and include of the OHCA Plan into the DPH State Health Plan

Customer Access to Restrooms in Retail Establishments

Effective: October 1, 2009

**SUMMARY:**

This bill provides access to employee restrooms in retail establishments to individuals with certain medical conditions. Specifically, a retail establishment with an employee restroom that typically is not open to the public must allow a customer to use the restroom during normal business hours if the restroom is maintained in a reasonably safe manner and all of the following conditions are met:

1. the customer presents written evidence from a licensed health care provider (physician, physician assistant, advanced practice registered nurse) that documents that the customer suffers from an "eligible medical condition" (such conditions are Crohn's disease, ulcerative colitis, inflammatory bowel disease, irritable bowel syndrome, celiac disease, or a medical condition requiring use of an ostomy device);
2. a public restroom is not immediately available to the customer;
3. at least three employees are working in the establishment at the time of the restroom access request; and
4. the employee restroom is located in an area of the establishment that does not present an obvious risk to the health or safety of the customer or an obvious security risk to the establishment.

The bill also (1) provides protection from liability for retail establishments and employees under certain conditions, (2) does not require an establishment to make physical changes to the employee restroom to accomplish the bill's purposes, and (3) makes violation of the bill's requirements an infraction.

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Public Act 09-130

HB 6336

Nurses Pursuing Advanced Degrees

Effective: July 1, 2009

**SUMMARY:**

This bill requires the Board of Trustees of the Community-Technical Colleges to take all feasible steps to maximize available federal funds to establish a nursing program at Northwestern Connecticut Community College.

\*House Amendment "A" eliminates provisions concerning a graduate assistantship program for nurses at two state universities and requires the Board of Trustees of the Community-Technical Colleges, rather than the Board of Governors of Higher Education, to seek federal funds to establish a nursing program.

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Public Act 09-133

HB 6391

Revisions to the HIV Testing Consent Law

Effective: July 1, 2009

**SUMMARY:**

This bill revises the law on consent for HIV-related testing. Specifically, the bill:

1. eliminates the requirement for separate, written or oral consent for HIV testing and instead allows general consent for the performance of medical procedures or tests to suffice;
2. clarifies that HIV testing is voluntary and that the patient can choose not to be tested;
3. eliminates the current requirement for extensive pre-test counseling for all HIV tests;
4. adds a requirement that an HIV test subject, when he or she receives a test result, be informed about medical services and local or community-based HIV/AIDS support services agencies; and
5. provides that a medical practitioner cannot be held liable for ordering an HIV test under general consent provisions.

## **GENERAL CONSENT FOR HIV TESTING**

The bill specifies that a person who gives general consent for medical procedures and tests is not required to also sign or be presented with a specific informed consent form relating to procedures or tests to determine HIV infection or antibodies to HIV. "General consent," under the bill, includes instruction to the patient that (1) as part of the medical procedures or tests, the patient may be tested for HIV and (2) such testing is voluntary and the patient can choose not to be tested for HIV or antibodies to HIV.

Under the bill, general consent that includes HIV-related testing must be given without undue inducement or any form of compulsion, fraud, deceit, duress, or other constraint or coercion. The medical record must document a patient's refusal of an HIV-related test.

## **PRE-TEST INFORMATION AND COUNSELING**

Under current law, informed consent to an HIV-related test must include a statement to the individual that includes (1) an explanation of the test, including the meaning of results and the benefits of early diagnosis and medical intervention; (2) acknowledgement that consent is not a precondition to receiving care but refusal to consent may affect the provider's ability to diagnose and treat; (3) an explanation of the procedures to be followed, including that the test is voluntary, and a statement advising of the availability of anonymous testing; and (4) an explanation of the confidentiality protections given confidential HIV-related information.

Also under current law, prior to receiving informed consent, the person ordering the test must explain AIDS and HIV-related illness and provide information about behaviors posing a risk for transmitting HIV infection.

The bill eliminates the provisions of current law governing HIV-specific informed consent.

## **POST-TEST RESULT COUNSELING**

Current law requires the person ordering an HIV-related test to provide the test subject or his or her authorized representative with counseling information when giving the test results. The bill specifies that such counseling initiatives are required as needed and also adds counseling

about available medical services and local or community-based HIV/AIDS support services agencies.

The law requires counseling or referrals (1) for coping with the emotional consequences learning of the test result; (2) concerning discrimination the test result disclosure could cause; (3) on behavior changes to prevent transmitting or contracting HIV infection; (4) for informing the person of available treatments; (5) to work towards involving a minor's parents or guardian in decisions about medical treatment; and (6) concerning the need of the test subject to notify his or her partners and, as appropriate, provide assistance or referrals for assistance in notifying partners.

## **BACKGROUND**

### ***CDC HIV Testing Guidelines and Recommendations***

In 2006, the federal Centers for Disease Control and Prevention (CDC) revised its HIV testing guidelines by recommending that separate written consent for HIV testing not be required for patients in all health care settings. Instead, general consent for medical care should be considered sufficient to encompass consent for HIV testing, according the CDC.

**REQUIRED ACTION**: HCS- Inform staff, providers of changes in new law.

Public Act 09-80

HB 6463

### ***Membership on Regional Planning Agencies***

Effective: October 1, 2009

## **SUMMARY:**

This bill increases the membership on regional planning agencies (RPAs), which currently operate in five of the state's 15 planning regions. Under current law, each municipality in an RPA region gets two representatives on the RPA. Those with populations over 25,000 get an additional representative for each additional 50,000 people or fraction thereof.

The bill makes each municipality's chief elected official (CEO) or his or her designee a representative on the RPA, thus increasing each

municipality's base representation from two to three. It similarly increases the representation of cities and boroughs within a town and whose boundaries are not conterminous with it. Current law gives these municipalities one representative each on the RPA. The bill makes the city and borough's CEOs or their designees representatives, thus increasing their membership to two.

The state's RPAs are Central Connecticut RPA, Connecticut River Estuary RPA, Greater Bridgeport RPA, Midstate RPA, and Southwestern Connecticut RPA.

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Public Act 09-165

HB 6466

*Projects of Regional Significance*

Effective: October 1, 2009

**SUMMARY:**

This bill requires each regional planning organization (RPO) to establish a voluntary process for applicants to state or local agencies, departments, or commissions to request a pre-application review of proposed projects of regional significance. There are three types of RPOs: regional councils of governments, regional councils of elected officials, and regional planning agencies. Under the bill, a project of regional significance is an open air theater, shopping center or other development to be built by a private developer that is planned to create more than (1) 500,000 square feet of indoor commercial or industrial space, (2) 250 housing units in one to three story building, or (3) 1,000 parking spaces.

The bill requires the RPO process to determine the components of the review. These components must include a procedure to assure that all relevant municipalities and regional and state agencies provide the applicant with (1) preliminary comment on the project, in a form determined by the agency; (2) summaries of the review process of each agency; and (3) an opportunity for the applicant to discuss the project with representatives of each relevant municipality or state agency at a meeting convened by the RPO. At least one representative from each relevant municipality and each state agency, department, or commission must participate in a review of the project at the RPO's request at a meeting convened for this purpose. This requirement

applies if the RPO notifies each agency, department, or commission of the meeting at least three weeks in advance. An RPO cannot convene more than one meeting for a particular project in any quarter of a calendar year. The bill does not prevent two or more RPOs from convening joint meetings to carry out the bill.

The results or information obtained from the preapplication review cannot be appealed under any provision of the statutes and are not binding on the applicant or any authority, commission, department, agency, or other official having jurisdiction to review the proposed project.

The RPO must prepare a report of the comments of the agencies reviewing the proposal and give a copy of the report to the applicant and each reviewing agency.

\*House Amendment "A" (1) narrows the scope of projects subject to the bill, (2) requires agencies to participate in the review only if they receive advance notice of the meeting, (3) limits the number of reviews on a project to one per quarter, (4) eliminates provisions that exempted information provided by an applicant or agency as part of the review from the Freedom of Information Act and barred agencies from considering this information in their subsequent deliberations, (5) bars appeals based on this information, (6) specifies that this information is not binding on the applicant or the agencies, and (7) makes minor related changes.

**REQUIRED ACTION**: The department may be asked to participate in a pre-application review held by a regional planning organization, of a project of regional significance. If so, each regulatory section will need to determine if the project falls under any of their review/permitting processes. If so, that section may be required to submit preliminary comments on the project and a summary of the review process, as well as participate in a meeting convened by the regional planning organization.

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Public Act 09-166

HB 6476

*A Program Review and Investigations Committee Pilot Program Utilizing Results-Based Accountability*

Effective: Upon Passage

## **SUMMARY:**

This bill requires the Program Review and Investigations Committee (PRI) to assess selected human service programs using results-based accountability (RBA) methods. The entities operating these programs must cooperate with the committee and provide the information it needs to assess the programs. The committee must report to the Appropriations Committee about the program by January 15, 2010.

The bill delays, for two years, PRI's review of agencies and programs the sunset law terminates on specified dates. The termination happens after the review unless the legislature reestablishes the programs.

## **RESULTS-BASED ACCOUNTABILITY PILOT**

The bill requires PRI to assess human services programs on a pilot basis using results-based accountability methods. In selecting the programs, PRI must consult with the Human Services Committee and the Appropriations subcommittee for Human Services.

In implementing the pilot, PRI must apply the bill's definition of RBA. RBA is a way to plan and budget funds for a program and measure its performance. It does these things by focusing on the extent to which the programs help produce the quality of life the state desires for its citizens. It identifies the performance measures and indicators showing the progress the state is making toward achieving that goal. It also identifies other programs and partners contributing to that end.

The entities running the programs must cooperate with PRI in its assessment. They must provide any books, records, and documents the committee needs to assess the programs' effectiveness.

PRI must report to the Appropriations Committee about the pilot program by January 15, 2010. The report must recommend whether to modify or terminate the programs and evaluate the effectiveness of the RBA methods. In evaluating the methods, PRI must recommend if they should be continued, expanded, or modified.

## **SUNSET REVIEW**

The sunset law automatically terminates 78 licensing, regulatory, and other state agencies and programs on set dates unless the legislature reestablishes them. But PRI must first review the public need for each

entity according to specified criteria and recommend to the legislature if the entity should be abolished, reestablished, modified, or consolidated. The bill delays for two years the entities' termination date as follows:

<i>Schedule Terminate Date</i>	<i>Extended Termination Date</i>
July 1, 2010	July 1, 2012
July 1, 2011	July 1, 2013
July 1, 2012	July 1, 2014
July 1, 2013	July 1, 2015
July 1, 2014	July 1, 2016

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Public Act 09-11

HB 6537

*Legislative Commissioners' Recommendations for Technical Revisions to the Public Health Statutes*

Effective: October 1, 2009

**SUMMARY:**

This bill makes technical changes in public health-related statutes.

**REQUIRED ACTION**: FLIS will educate staff; identify DDS person to receive reports.

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Public Act 09-147

HB 6582 (VETOED)

*Establishing the Connecticut Healthcare Partnership*

Effective: July 1, 2009; except for the provisions about (1) self-insuring the state plan, (2) needing SEBAC's agreement before opening the state plan to other groups, (3) municipalities acting as a single entity to obtain employee health insurance, and (4) covering dependents to age 26 under the state plan, which are effective upon passage.

**SUMMARY:**

This bill requires the comptroller to convert the state employee health insurance plan, excluding dental, to a self-insured arrangement for

benefit periods beginning July 1, 2009 and later. (Pharmacy benefits are already self-insured. ) It authorizes her to merge, on or after January 1, 2010, any health benefit plans she arranges into the self-insured state plan. The bill requires that a company contracting with the state to provide administrative services for the self-insured state plan must charge the state its lowest available rate.

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Public Act 09-231

HB 6585

Act Concerning Regionalism

Effective: July 1, 2011 for the sales tax segregation provisions; October 1, 2009 for the remaining provisions.

**SUMMARY:**

This bill requires the board of directors of each federal economic development district to send a copy of the district's regional economic development plan to the Office of Policy and Management (OPM) secretary. The secretary must approve the plan within 30 days after receiving it.

The bill allows the chief elected officials of two or more municipalities that belong to the same federal economic development district to enter into mutual agreements to (1) promote regional economic development and (2) share the real and personal property tax revenue from new economic development. The agreement must (1) provide that the municipalities not compete for new economic development and (2) specify the types of projects subject to the agreement. The municipalities must send a copy of the agreement to the OPM secretary who must determine, within 30 days, whether it is consistent with the bill's requirements. The secretary must send his determination to the revenue services (DRS) commissioner.

The bill requires the DRS commissioner to enter into a memorandum of agreement (MOA) with each municipality participating in an approved agreement to segregate part of the sales and use tax derived from income, items, or transactions that occur in the participating municipalities after June 30, 2010. (It is unclear how revenue segregation will work with regard to MOAs entered into before July 1, 2011, since the segregation provision is not effective until July 1, 2011). This money

must be allocated to the member municipalities on a per capita basis, based on the Department of Public Health's (DPH) latest annual population estimate. The municipalities must use the money for the purposes they jointly determine.

The bill requires regional councils of elected officials to identify opportunities and obstacles to interlocal agreements that promote regional cooperation and promote agreements between towns entered into under the bill.

\*House Amendment "A" (1) eliminates a provision allowing municipalities that are parties to an agreement to impose a local hotel tax of up to 1% and (2) delays the effective date of the sales tax segregation provisions by one year.

## **AGREEMENT AMONG MUNICIPALITIES**

Under the bill, the agreement must provide for:

1. identification of areas for (a) new economic development, (b) open space and natural resource preservation, and (c) transit oriented development, including housing;
2. capital improvements, including the shared use of buildings and other capital assets;
3. regional energy consumption, including strategies for cooperative energy use and development of distributive (on-site) generation and sustainable energy projects; and
4. promotion and sharing of arts and cultural assets.

The agreement must also include terms providing for at least three municipal cooperative programs and at least three educational cooperative programs. These can cover such areas as:

1. collective bargaining;
2. purchasing cooperatives;
3. health care pooling with each other or the state;

4. regional shared school curriculum and special education services, through regional education service centers; and
5. any other mutually agreed upon initiatives.

Each party to the agreement must participate in at least one municipal cooperative and one educational cooperative program. The bill explicitly states that the parties do not have to participate in all of these cooperative programs.

The agreement must be negotiated and contain all provisions on which the municipalities agree. The mill rate used to determine the amount of taxes imposed on the new economic development must be the mill rate of the municipality where the development is located. This municipality must maintain a separate list describing these properties.

The agreement must establish procedures for its amendment and termination and withdrawal of members. It must provide an opportunity for public participation. The legislative body of each participating municipality must adopt a resolution to approve the agreement. The legislative body is the council, commission, board, body or town meeting, or other body that has or exercises general legislative powers and functions in a municipality. A municipality is a town, city, or borough; consolidated town; and city or consolidated town and borough.

The participating municipalities must send a copy of such agreement to the OPM secretary. Within 30 days after receiving the plan, the secretary must make a written determination as to whether it is consistent with the bill's requirements. The secretary must send a copy of his determination to each participating municipality and the DRS commissioner.

**REQUIRED ACTION:** Inform DWS staff of the new requirements.

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Public Act 09-232

HB 6678

*Revisions to Department of Public Health Licensing Statutes*

Effective: October 1, 2009, except for the sections on (1) the Health Equity Commission, geothermal wells, and repeal of the school-based health center

entrance requirement, which take effect on passage and (2) home health agency inspections and umbilical cord blood, which take effect on July 1, 2009.

## **SUMMARY:**

This bill makes a number of substantive and minor changes to laws governing Department of Public Health (DPH) programs and health professional licensing. The changes related to DPH programs address funeral home practices and death records, the Connecticut Tumor Registry, mass gatherings, the home health agency inspection schedule, and geothermal wells. The professional licensing changes affect physicians, nursing home administrators, dental hygienists, and veterinarians.

The bill requires certain health care practitioners to inform pregnant women about umbilical cord blood and cord blood banks. And it makes minor changes in laws concerning the Health Equity Commission and school-based health centers.

### **§ 1 & 13 — FUNERAL HOME PRACTICES**

This section makes changes to the licensed embalmer and funeral director statutes to allow religious beliefs and customs of the deceased person to be honored. It also requires that all bodies that are to be entombed in a crypt or a mausoleum to be sealed in a zinc-lined or ABS sheet plastic container.

It changes the statute mandating any person, firm, partnership or corporation engaged in the funeral service business keep the following records for 6 years after the death of the individual.

- a. funeral services
- b. prepaid funeral contracts
- c. escrow accounts
- d. death certificates
- e. burial permits
- f. authorizations for cremation
- g. documentation of receipt of cremated remains
- h. written agreements used in making arrangements for final disposition of dead human bodies, including, but not limited to, copies of the final bill and other written evidence of agreement or obligation furnished to consumers
- i. copies of price lists

## **§ 2 — PENALTIES FOR NURSING HOME ADMINISTRATORS**

This section makes technical revisions concerning the Department's authority to take appropriate disciplinary action against a Nursing Home Administrator who violates any provision of the state or federal law.

## **§ 3 — MEDICAL RESIDENTS' PERMITS**

Prior to a person participating in an intern or resident program, they must receive a permit from the DPH. This section makes technical revisions to allow the DPH to take appropriate disciplinary action against the intern/resident if they have been terminated from the program they are working for, but continue to practice.

## **§ 4 — DENTAL HYGIENISTS**

This section makes a technical revision to the definition of "Public Health Facility" in section 20-126/ Dental Hygienist Definitions. Scope of practice. Limitations.

## **§§ 5 & 6 — MASS GATHERING LICENSE**

These sections make changes to the mass gathering license needs by changing the amount of people from three thousand to two thousand or more people and hours of operation from eighteen to twelve or more consecutive hours within 15 (previously 30) days of the event. It also requires a separate license for each day and each location in which two (previously three) thousand or more people assemble or can reasonably be anticipated to assemble. The cost of the permits did not change.

Both sections 5 and 6 are critically important to include the local emergency medical services primary service area responder into the planning stage of the event. If there is not a primary service area responder, then the provider of local emergency medical care and transport service must be consulted in the planning stage. This would assure that proper access and egress to the event site is identified and can be maintained in the even of medical emergency. This would also allow the local and mutual aid emergency medical services to plan and "gear up" as necessary to assure that day-to-day operations are met as well as the needs of the mass gathering event are properly addressed.

## **§ 7—CONNECTICUT TUMOR REGISTRY**

The section updates the statute to reflect current practice and reporting guidelines to provide the Department with the authority to take action against a healthcare provider who doesn't provide us access to appropriate records to the registry. In addition, the changes will allow

the Department and health care providers flexibility with reporting requirements, which change over time due to changes in diagnosis, treatment and prognostic considerations in oncology. This will ensure the complete and timely surveillance of cancer incidence within the State of Connecticut. If hospitals do not comply, they can be fined up to \$250.00 per day. Hospitals must submit within 9 months of the first contact with the hospital, clinical lab or health care provider.

#### **§§ 8, 12, 18, 19 — DEATH-RELATED RECORDS**

Makes technical changes to allow a subregistrar to issue removal, transit and burial permits along with cremation permits during the hours when the office of vital records in the town where the death occurred is closed. The bill makes technical changes and allows a subregistrar to issue cremation permits during the hours when the office of vital records is closed.

#### **§ 9 — COMMISSION ON HEALTH EQUITY**

Makes changes to section 38a-1051 to include “gender” when the Commission on Health Equity is evaluating policies, procedures, activities and resources regarding the health status for citizens of Connecticut.

#### **§§ 10 & 11 — VETERINARIAN CONTINUING EDUCATION**

Establish mandatory continuing education requirements for licensed veterinarians. The licensee applying for license renewal shall earn a minimum of twenty-four contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; and (2) reflect the professional needs of the licensee in order to meet the veterinary health care needs of the public. Provisions for waivers and time extensions have been written into the language. Allows the Department to take action against a veterinarian pursuant to section 19a-17 if they failed to comply with continuing education requirements.

#### **§ 14 — HOME HEALTH AGENCY INSPECTIONS**

Allows for inspections of Medicare Home Health Care agencies to take place every 3 years rather than every 2 which aligns the Federal and state inspection schedules.

#### **§ 15 — HEALTH CARE PROVIDER EDUCATION PROGRAMS**

Technical change where the Department is named in an old statute 4a-16 as providing care for patients. Deleted the Department of Public Health and left DDS and DMHAS.

#### **§ 16 — PHYSICIAN CONTINUING MEDICAL EDUCATION**

Adds cultural competency to the continuing education requirements for physicians. Includes the registration period beginning on and after October 1, 2010.

#### **§ 17 — PHYSICAL THERAPY**

Allows Physical therapists to perform low level light laser therapy for the purpose of accelerating tissue repair, decreasing edema or minimizing or eliminating pain.

#### **§ 20 — GEOTHERMAL WELLS**

Allows the Department of Public Health in concurrence with the Departments of Consumer Protection and Environmental Protection to issue a variance to the regulations of Connecticut State Agencies to an institution of higher education for the installation and study of standing column geothermal wells.

#### **§ 21 — UMBILICAL CORD BLOOD**

Mandates physicians or health care providers providing care for women in their last trimester of pregnancy to provide women with timely, relevant and appropriate information sufficient to allow her to make an informed and voluntary choice regarding options to bank or donate umbilical cord blood following the delivery of a newborn child.

#### **§ 22 — VITAL RECORDS**

Allows transmission of vital records to other offices of vital statistics outside the state of Connecticut. After acquiring the records the office must dispose of them in the correct way.

#### **§ 23 & 24 — BURIAL PROCEDURES**

These sections discuss how the noted official in charge of a dead body must take care of it accordingly with family or declaring it an expense of the state. Notice must be given to the Department of Public Health within twenty-four hours after the body has come into its possession. Any person or association controlling a cemetery shall disclose to each consumer, in writing at the time of the sale of any item or service, any dispute resolution procedure. This written notice must indicate that the consumer may contact the Department of Public Health or local public health director if the consumer has any complaints.

#### **§ 25 through 38**

Sections 25 – 38 (Does not include section 28) are needed to replace outdated language with modern terminologies. Other language changes include allowing the Commissioner to annually approve a list that sets the minimum equipment requirements for ambulances, motorcycles and other rescue vehicles and making the renewal cycle for EMT certification consistent for all providers, regardless of how long the provider has been certified.

**§ 27 — MINIMUM EQUIPMENT REQUIREMENTS**

Allows the Commissioner to annually issue a list of minimum equipment requirements for ambulances and rescue vehicles as consistent with the current national scope of practice and gives services up to 1 year from date of publish to bring the equipment on-line. Distributes the list to all EMS organizations and sponsor hospital medical directors, and make such list available to other interested stakeholders.

**§ 28 — PHARMACEUTICALS**

Corrects SB 1048 subsection (a) to delete the Insurance Commissioner from the plan to implement and maintain a prescription drug purchasing program and procedures to aggregate or negotiate the purchase of pharmaceuticals for pharmaceutical programs benefiting SAGA, Husky Plan, Part B, Charter Oak and Con PACE and inmates at Corrections.

**§ 29 — EMERGENCY MEDICAL SERVICE**

Updates the language of the EMS Advisory board members to change state medical director to state “EMS” medical director. Also updates the language for including an advanced emergency medical technician instead of the old language of EMT-intermediate.

**§ 30 through 34, & 37, 38**

Updates the language to delete the word “control” from Medical oversight, which is old terminology. Also updates the language for emergency medical technician (deletes the word basic) and advanced emergency medical technician (adding advanced and deleting the word intermediate).

**§ 35 — MOTORCYCLE RESCUE REQUIREMENTS**

Updates section 19a-194 to mandate the Commissioner of DPH to issue a yearly list of minimum equipment requirements that a motorcycle must carry to operate as a rescue vehicle.

**§ 36 — RECERTIFICATION**

Updates the language in section 19a-195a to change the emergency medical services technicians recertification every three years rather than every two years. Also requires each emergency services technician who is recertified every 3 years to complete a 30 hour refresher course (previously 25 hour).

**§ 39 & 40 — LARGE ANIMAL CREMATORIUM**

Will not authorize a large animal crematory within 500 feet of any residential structure or land used for residential purposes not owned by the owner of the crematory.

**§ 41 — FARM MAINTENANCE**

Pig sty language - If a farm has been in continuous use as a farm for not less than 50 years it may continue to be maintained provided the barn is not closer than 200 feet from any inhabited house.

**§ 42 — CHILD DAY CARE SERVICES**

Makes Solar Youth exempt from obtaining a license as a Child Day Care Center.

**§ 43 — INFECTIOUS DISEASE**

Fixes the definition of “infectious disease” that passed in SB 1010 (PA 09-76). Changes Pandemic Influenza to Novel influenza A virus infections with pandemic potential, as defined by the National Centers for Disease Control and Prevention.

**§ 44 — LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS**

Makes a technical change to allow Marriage and Family Therapists to compensate their supervisor, consistent with other professions.

**§ 45 & 46 — BARBER, HAIRDRESSER, COSMETICIAN LICENSURE**

Deletes the mandate for a person to take an English proficiency examination when applying for a barber/hairdresser/cosmetician or similar license.

**§ 47 & 48 — PUBLIC DRINKING WATER**

The language in this section will allow under certain circumstances Class I land associated with a groundwater source for use for public drinking water purposes to obtain a permit to lease to another water company. Currently, Class I land cannot be leased out to another water company for any reason.

#### **§ 49 through 51 — FLOUROSCOPY**

Clarifies the type of equipment that can be used by a Physicians Assistant, Radiographer and Radiologic technician. This will allow them to engage in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures.

#### **§ 52 — PRESCHOOL AND CHILD CARE SERVICES**

Clarifies the language in Special Act 09-3 regarding the single form that may be used by preschool and child care services for daily attendance records for children and staff.

#### **§ 53 - 67 & 78 - 82 — SPEECH PATHOLOGIST AND AUDIOLOGIST**

Separates the Audiologist and Speech pathologist professions into 2 different types of licenses. Uses existing statutory language adding CEU's. (Effective October 1, 2009)

#### **§ 68 & 83 through 90 — RADIOLOGY**

Establishes a carve-out for Radiology Technicians currently licensed in the Quinnipiac University Radiology Assistant program, within available appropriations. Creates the Radiologist Assistant licensing category. (Effective July 1, 2011)

#### **§ 69 — ABANDONED CEMETARY**

Permits towns to acquire abandoned cemeteries if they wish.

#### **§ 70 — SUNSHINE HOUSE PILOT PROGRAM**

Creates Sunshine House pilot program. It must comply with the provisions of sections 19a-638 and 19a-639 of the general statutes by 2011. By 2014 licensure shall comply with the provisions of section 19a-491 of the general statutes.

#### **§ 71 — EMERGENCY MEDICAL SERVICES**

When considering expansion in emergency medical services the Commissioner shall consult with the Office of Emergency Medical Services and the emergency medical services council of such region and shall hold a public hearing to determine the necessity for such services. This bill changes language so that a primary service area responder that operates in the service area identified in the application shall, upon request, be granted intervenor status with opportunity for cross-examination.

#### **§ 72 — ANATOMIC PATHOLOGY BILLING**

Speaks about billing for anatomic pathology services. Can only bill patient, responsible insurer or a governmental agency or that agencies public or private agency.

**§ 73 — MARRIAGE LICENSE**

Couples can only obtain marriage licenses in the towns where the marriage is taking place.

**§ 74 through 77**

Names DPH as the State Regional Health Information Organization. Creates a Health Information Technology and Exchange Advisory Committee. Allows DPH to apply for funding base on guidance from this advisory committee. Also mandates the Department to fulfill it's obligation to print and distribute the Health Information Technology plan.

**§ 91 — SCHOOL CLINIC LOCATION REQUIREMENTS**

Repeals section 10-292p of the CT General Statutes School-based health clinic entrance requirements from the statues. This section required any school based health clinic located in or attached to a school building constructed on or after July 1, 2009 that shares a first floor exterior wall with the school building include an entrance that is separate from the entrance of the school building.

**§ 98, 101, & 102 — INFORMATION BETWEEN DPH & DCF**

These sections will allow current practice of information sharing to continue. However, it will clarify for Department of Children and Family (DCF) its authority to release information to DPH.

**§ 99 & 100 — YOUTH CAMP CLOSURE**

Will allow us to only shut down a specific hazardous activity that occurs at a licensed youth camp. Current statute mandates the Department to suspend the full operation of a youth camp when an immediate hazardous activity or condition has been identified thereby, closing the camp until the incident has been addressed.

**§ 103 — ISSUANCE OF DAY CARE LICENSE**

Will allow the Department to issue a license to a day care provider even though there may already be a license at the location where the original provider has vacated the premises but has refused to relinquish their

license. Currently only 1 license can be held at a location even if the business is not operating.

#### **§ 104 — DAY CARE LICENSING**

Will expedite licensing applications for Day Care centers being run in a municipal building.

#### **§ 105 & 106**

This section repeals sections 7-68 and 7-72 of the CT General Statutes. 7-68 Issuance of disinterment or removal permit. 7-72 - Sextons' reports. Fines.

#### **REQUIRED ACTION:**

On or after July 1, 2009:

1. Seek private and federal funds, for the development of a statewide health information exchange. Facilitate the implementation and periodic revisions of the health information technology plan including the implementation of an integrated statewide electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payors and patients.
2. Develop standards and protocols for privacy in the sharing of electronic health information.

On or after November 1, 2009:

1. The Commissioner of Public Health shall submit any proposed application for private or federal funds that are to be used for the development of health information exchange to the health information technology and exchange advisory committee. The Commissioner shall offer at least one member of the committee the opportunity to participate on any review panel constituted to effectuate the provisions of this subsection.
2. The DPH within available funds, provide administrative support the committee (Committee to be designated by 10/1/09) and shall assist the committee in all tasks, including, but not limited to, (1) developing the application for the grants-in-aid authorized under subsection (g) of this section, (2) reviewing such applications, (3) preparing and executing any assistance agreements or other agreements in connection with the awarding of such grants-in-aid, and (4) performing such other administrative duties as the committee deems necessary. The Commissioner may contract for this administrative support.

No later than 2/1/10 and annually until 2/1/15: The Commissioner of Public Health and the health information technology and exchange advisory committee shall report to the Governor and the General Assembly on (1) any private or federal funds received during the preceding quarter and, if applicable, how such funds were expended, (2) the amount of grants-in-aid awarded to eligible institutions, (3) the recipients of such grants-in-aid, and (4) the current status of health information exchange and health information technology in the state.

By July 1, 2009: Submit the CT State Health Information Technology Plan to the GA (Planning Branch)

By January 1, 2010 DPH must work with DSS and SDE to develop a single form that may be used by daycare providers to report attendance, staff qualifications and work schedules.

In Section 47 & 48 the applications will be reviewed by the Drinking Water Section, which already reviews similar applications under CGA 25-32.

Section 20 allows DPH to issue variances for geothermal open loop wells in certain areas for study. Section 39 does not allow for large animal crematory within 500 ft. of any residential structure not owned by the owner of the crematory. Section 58 allows the Commissioner to refuse to license someone based on certain conditions.

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Public Act 09-155

SB 755

*The Use of Asthmatic Inhalers and Epinephrine Auto-Injectors while at School*

Effective: August 15, 2009

**SUMMARY:**

This bill requires, rather than allows, the State Education Department (SDE) to adopt regulations governing medication administration by school personnel and student self-administration. It specifies that the latter must address students using asthmatic inhalers and epipens. It permits licensed athletic trainers employed by a school board to administer medication to students under the general supervision of a school nurse.

Finally, the bill requires school boards to make their plans for managing students with life-threatening food allergies publicly available on the Internet or otherwise.

\*Senate Amendment "A" (1) changes the effective date to August 15, 2009 from October 1, 2009, (2) eliminates respiratory care therapists from the health care providers who can authorize a student's use of an inhaler, (3) eliminates a requirement that mandated periodic school health assessments indicate whether a child has been certified to use an inhaler or epipen at school, (4) adds out-of-state doctors and reinstates out-of-state dentists, and (5) adds the requirement for public availability of school plans for students with life-threatening food allergies.

### **REGULATIONS ON STUDENTS' ASTHMA AND ALLERGIES**

School boards do not have to allow medication administration by school personnel and students' self-medication, but if they do they must follow state regulations. The bill requires, rather than permits, SDE to adopt such regulations. (The Public Health Code already contains such regulations (10-212a-1 to -7). ) It requires the regulations on self-administration to include permitting a child diagnosed with asthma or allergies to possess an inhaler or epipen at school if a parent or guardian submits to the school nurse authorization to that effect signed by the parent or guardian and a health care provider who can prescribe medication.

Current law already requires the regulations to require a written order from a doctor, physician assistant, dentist, APRN, podiatrist, or optometrist and written authorization by a parent to authorize school personnel or a student to administer or self-administer a medication. The bill adds physicians licensed in another state to this list of authorizing practitioners. Out-of-state dentists are already authorized.

### **MEDICATION ADMINISTRATION BY ATHLETIC TRAINERS**

The bill adds licensed athletic trainers employed by a school board to the list of school personnel who may administer medications to students under a school nurse's general supervision. By law, these personnel are immune from civil liability for any acts or omissions in administering medication, unless they constituted gross, willful, or wanton negligence.

### **LOCAL FOOD ALLERGY RESPONSE PLANS**

The law requires school boards to develop and implement plans for managing students with life-threatening food allergies. The bill requires them to make their plans available on the board's or each school's website, or, if such websites do not exist, by some other means it selects. It also requires boards to provide notice about the plans along with the written statement about pesticide applications they must, by law, provide parents and guardians. School superintendents must attest annually to the State Education Department that their districts are implementing these plans.

**REQUIRED ACTION:** Inform staff about changes and update website to include information about new rules.

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Public Act 09-131

SB 760

*School Crisis Response Drills and Fire Drills*

Effective: October 1, 2009

**SUMMARY:**

This bill requires, rather than allows, school boards, once every three months, to substitute crisis response drills for the monthly fire drills required in schools under their jurisdiction. The bill also requires the boards to conduct one of the fire drills no later than 30 days after the first day of each school year.

The bill (1) requires the boards to develop the crisis response drill format in consultation with the appropriate law enforcement agency and (2) allows an agency representative to supervise and participate in the drill.

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Public Act 09-239

SB 838

*Consumer Privacy and Identity Theft*

Effective: October 1, 2009, except the provisions relating to the penalties for violating the duty to safeguard personal data investigations, the privacy protection account, appeals, and regulations, which are effective upon passage.

## **SUMMARY:**

This bill makes numerous changes in laws relating to identity theft, Social Security numbers (SSNs), and the dissemination of personal identifying information.

### ***Restrictions on Disclosing Social Security Numbers***

With certain exceptions, the law prohibits individuals and businesses from publicly disclosing Social Security numbers. The prohibition does not prevent the numbers from being (1) collected, used, or released as required by state or federal law or (2) used for internal verification or administrative purposes.

Specifically, the law prohibits any person, firm, corporation, or other entity, other than the state or its political subdivisions, from:

1. intentionally communicating or otherwise making available to the general public an individual's Social Security number;
2. printing anyone's Social Security number on any card that the person must use to access the person's or entity's products or services;
3. requiring anyone to transmit his Social Security number over the Internet, unless the connection is secure or the number is encrypted; or
4. requiring anyone to use his Social Security number to access an Internet web site, unless a password or unique personal identification number or other authentication is also required to access it.

The penalty for willful violations is a fine of up to \$ 100 for the first offense, up to \$ 500 for a second offense, and up to \$ 1,000 or six months in prison for each subsequent offense (CGS § 42-470).

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Public Act 09-94

SB 981

*Availability of Automatic External Defibrillators in School*

Effective: July 1, 2009

**SUMMARY:**

This bill requires a school board to have at each school in its jurisdiction, if funding is available, (1) an automatic external defibrillator (AED) and (2) school staff trained in its use and in cardiopulmonary resuscitation (CPR). The bill allows school boards to accept donated AEDs under certain conditions. It also allows boards to accept gifts, donations, and grants for AED acquisition and staff training costs.

It also requires each school to develop emergency action response plans addressing appropriate use of school personnel to respond to individuals experiencing sudden cardiac arrest or similar life-threatening emergencies.

**REQUIRED ACTION** : By July 1, 2010, each school must develop an emergency action response plan addressing the appropriate use of school personnel to respond to individuals experiencing sudden cardiac arrest or similar life-threatening emergency while on school grounds. Also by that date, each school with an athletic department or organized athletic program must develop an emergency action response plan addressing appropriate school personnel response to the same circumstances while attending or participating in an athletic event or practice on school grounds.

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Public Act 09-177

SB 1009

*Technical Changes to Title 29 to Incorporate the State Fire Prevention Code*

Effective: Various, see below.

**SUMMARY:**

This bill makes numerous unrelated changes in various statutes affecting the fire safety and fire prevention codes, state building inspector, manufacturing establishments, explosives and fireworks, local fire marshals, and hazardous chemicals. Many are technical, conforming, and updating changes.

The bill makes substantial changes in the penalties for certain fire safety violations by subjecting violators to the penalties provided under an existing provision for violations of the Fire Prevention Code.

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Public Act 09-59

SB 1089

Automatic External Defibrillators

Effective: October 1, 2009

**SUMMARY:**

This bill provides immunity in a lawsuit for damages for acts arising out of a person's or entity's negligence in providing or maintaining an automatic external defibrillator (AED). It specifies that immunity does not apply to gross, willful, or wanton negligence.

\*Senate Amendment "A" (1) expands the immunity provision to anyone who provides or maintains an AED and not just licensed health clubs and (2) changes the bill's effective date from January 1, 2010 to October 1, 2009.

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Public Act 09-2, SSS

HB 7004

Authorizing And Adjusting Bonds Of The State For Capital Improvements,  
Transportation And Other Purposes

Effective: Upon Passage

**SUMMARY:**

**Section 34 (d)**

The proceeds of the sale of said bonds shall be used for the purpose of providing grants-in-aid and other financing for the projects, programs and purposes hereinafter stated:

(d) For the Department of Public Health: Grants-in-aid, not exceeding \$7,000,000, (1) for hospital-based emergency service facilities, (2) to community health centers and primary care organizations for the purchase of equipment, renovations, improvements and expansion of facilities, including acquisition of land or buildings.

Implementing The Provisions Of The Budget Concerning Human Services And Making Changes To Various Social Services Statutes

Effective: Upon Passage

**SUMMARY:**

**§§ 32, 40 — NURSING HOME AND ICF-MR RATE FREEZES**

The bill freezes at FY 09 levels, the Medicaid rates the state pays in FY 10 and FY 11 to nursing homes and intermediate care facilities for people with mental retardation (ICF-MR). But facilities that would have received a lower rate on July 1, 2009 because of their interim rate status or agreement with DSS will receive that lower rate.

The bill also eliminates fair rent increases to nursing home rates in FY 10 and FY 11 except for homes that have an approved certificate of need (CON). Current law requires DSS to add a fair rent increase to nursing home rates for homes that have undergone a material change in circumstances related to fair rent.

Nursing homes must apply for a CON to establish new, additional, expanded or replacement facilities, services, or functions; bed expansion, reduction, relocation, or conversion; certain capital expenditures; or to close the facility.

**§ 44 — MEDICATION ADMINISTRATION BY UNLICENSED PERSONNEL IN RESIDENTIAL CARE HOMES**

The bill requires the DPH commissioner to revise regulations governing medication administration by unlicensed personnel in RCHs that admit residents requiring medication administration assistance to include the following:

1. the requirement that each RCH designate unlicensed personnel to obtain certification and ensure that they do;
2. criteria homes must use to determine the appropriate number of unlicensed personnel who will obtain certification; and

3. required training in identifying the types of medication that unlicensed personnel can administer.

It also requires that by January 1, 2010, each RCH ensure that the number of unlicensed personnel it determined appropriate actually obtain certification to administer medication. Once certified, they can administer medication, except by injection, to RCH residents unless a resident's physician specifies that a medication be administered only by licensed personnel.

The bill permits the DPH commissioner to implement policies and procedures to administer the provisions of this section while in the process of adopting them in regulation, provided notice is published in the *Connecticut Law Journal* no later than 20 days after they are implemented. The policies and procedures are valid until final regulations are adopted.

Current law requires the commissioner to establish regulations allowing unlicensed personnel in RCHs to obtain certification to administer medication. The regulations must establish on-going training requirements, including initial orientation, residents' rights, behavioral management, personal care, nutrition and food safety, and general health and safety.

## **§ 56 — INTERPRETER SERVICES UNDER MEDICAID**

The bill establishes a February 1, 2011 deadline for the DSS commissioner to amend the

Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a "covered service" under the Medicaid program (See BACKGROUND). PA 07-185 directed the commissioner to amend the state plan. PA 08-1 required him to expedite amending the plan by June 30, 2009. The commissioner has not amended the state plan.

The bill also requires the commissioner, by February 1, 2011, to develop and implement the use of medical billing codes for foreign language interpreter services for the HUSKY Part A and B and fee-for-service Medicaid programs. It requires each managed care organization that contracts with DSS to provide interpreter services under HUSKY Part A to submit semiannual reports to DSS (by June 1<sup>st</sup> and December 31<sup>st</sup>) on the interpreter services provided to these beneficiaries. Within 30 days

of receiving the report, DSS must submit a copy to the Medicaid Managed Care Council.

### **§ 61 — SCHOOL-BASED CHILD HEALTH PROGRAM**

Federal law requires local education agencies (LEA) to identify all children with disabilities who are in need of special education and “related” services. Although the LEAs must provide the services, federal Medicaid law provides federal reimbursement (DSS, through the School-Based Child Health Program, bills Medicaid for 100% of what the LEA spends, keeps one half of the reimbursement, and passes the other half to the participating LEAs) for related services.

The bill requires the DSS commissioner, beginning with FY 09, to exclude any enhanced federal medical assistance percentages (FMAP) in calculating the federal portion of the Medicaid claims for this program. Before the federal stimulus legislation passed, the federal match or FMAP was 50%, which meant for every \$ 1 the state spent on the Medicaid program the federal government would reimburse it \$ . 50. The stimulus temporarily increased the FMAP by 12%, which raised Connecticut's match from 50% to 62%.

### **§ 62 — FAMILY PLANNING MEDICAID WAIVER**

PA 05-120 directed the DSS commissioner to apply for a family planning waiver for adults in households with income up to 185% of the FPL who are not otherwise eligible for Medicaid. The bill requires the commissioner, if he does not apply by February 1, 2010 to submit a written report to the Human Services and Appropriations committees by February 2, 2010 (1) explaining why he did not seek the waiver and (2) estimating the fiscal impact that would result from the waiver approval in one calendar year.

### **§ 63 — HIV AND AIDS MEDICAID WAIVER**

The bill requires the DSS commissioner, by February 1, 2010, to apply for a 1915(c) home and community-based services Medicaid waiver to develop and implement a program providing home and community-based services to up to 100 Medicaid beneficiaries who (1) have tested positive for human immunodeficiency virus (HIV) or have immune deficiency syndrome (AIDS) and (2) would remain Medicaid-eligible if admitted to a hospital, nursing home, or ICF-MR or would require Medicaid-covered care in these facilities without the waiver services.

The bill provides that an individual who meets these requirements is eligible to receive services deemed necessary by the commissioner to meet his or her needs in order to avoid institutionalization.

If the commissioner does not apply by the deadline, he must submit a written report to the Human Services and Appropriations committees by February 2, 2010 (1) explaining why he did not seek the waiver and (2) estimating the fiscal impact resulting from the waiver approval in one calendar year.

#### **§ 86 — NURSING HOME FINANCIAL ADVISORY COMMITTEE**

The bill removes the director of the Office of Fiscal Analysis from the Nursing Home Financial Advisory Committee's membership. It also designates as the representative of the nonprofit and for profit nursing home industries: the executive director of the Connecticut Association of Not-for-Profit Providers for the Aging and the executive director of the Connecticut Association of Health Care Facilities or their designees. The DSS and DPH commissioners, the secretary of OPM, and the executive director of the Connecticut Health and Educational Facilities Authority (CHEFA) or their designees remain committee members. The bill also removes the current requirement that vacancies be filled by the appointing authority.

The bill requires the committee to recommend appropriate action to the DPH commissioner, as it must currently do for the DSS commissioner, when it receives a report relating to nursing homes' financial solvency and quality of care. It requires the DSS commissioner to submit quarterly reports to the committee concerning any nursing home's pending interim rate request. These reports must (without identifying a facility by name) list (1) the amount of each requested increase, the reason for the request, and the resulting rate if the request is granted.

Starting January 1, 2010, the bill requires the committee to report annually on its activities to the Appropriations Committee, as well as the Human Services, Public Health, and Aging committees. And starting January 1, 2010, the committee must also meet quarterly with the chairpersons and ranking members of the Appropriations, Human Services, and Public Health Committees and the long-term care ombudsman to discuss its activities.

**REQUIRED ACTION**: HCS- Revise regulations governing medication administration by unlicensed personnel in RCHs that admit residents requiring medication administration assistance.

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Public Act 09-7, SSS

HB 7007

*Implementing The Provisions Of The Budget Concerning General Government  
And Making Changes To Various Programs*

Effective: Upon Passage

**SUMMARY:**

**§ 49 — COMMISSION ON ENHANCING AGENCY OUTCOMES**

The bill expands the membership of the Commission on Enhancing Agency Outcomes created by PA 09-2 by adding the chairpersons of the Legislative Program Review and Investigations Committee, or their designees. Currently, the chairpersons and ranking members of the Appropriations Committee serve on the commission. The bill permits the committee chairpersons to be represented by designees, but not the ranking members.

Currently, the commission charge includes consideration of the merging of state agencies including, specifically, (1) the Department of Mental Health and Addiction Services and the Department of Social Services and (2) the Connecticut Commission on Culture and Tourism, portions of the Office of Workforce Competitiveness, and the Department of Economic and Community Development. The bill (1) eliminates these references to specific agencies in the commission's charge to consider merging state agencies and (2) adds consideration of streamlining state operations to its charge.

The bill also (1) requires the Legislative Program Review and Investigations Committee, as it determines and within existing budgetary resources, to assist the commission and (2) extends and revises the commission's reporting requirements. Currently, the commission has to submit a report of its findings and recommendations to the governor, the House speaker, and the Senate president by July 1, 2009 and the commission terminates no later than that date. The bill, instead, gives the commission until February 1, 2010 to submit an initial report identifying subjects for further study and until December 31, 2010

to submit a full report on its findings and recommendations. It allows the commission to continue in existence until December 31, 2011.

EFFECTIVE DATE: Upon passage

#### **§ 154 — HUMAN RIGHTS REFEREES**

The bill reduces the number of human rights referees over the next approximately two years. On the date the bill passes, the number is reduced from seven to five. They serve until (1) the term they were appointed to fill expires or July 1, 2011, whichever is earlier, and (2) a successor is appointed and qualified. The governor fills any vacancies with the advice and consent of the General Assembly to serve until July 1, 2011.

Beginning July 1, 2011, the number of referees is reduced from five to three. Just as under current law, the governor appoints them with the advice and consent of the General Assembly to serve a three-year term.

The governor may remove any of the referees for cause.

EFFECTIVE DATE: Upon passage

#### **§ 155 — TASK FORCE ON DIVISION OF ADMINISTRATIVE HEARINGS**

The bill establishes a 24-member task force to develop recommendations for establishing within the CHRO a Division of Administrative Hearings that would conduct impartial hearings on contested cases brought by or before the departments of Children and Families, Transportation, and Motor Vehicles; CHRO; and the Board of Firearms Permit Examiners.

The task force members are:

1. the chairs and ranking members of the Government Administration and Elections, Human Services, Judiciary, and Transportation committees, or their designees;
2. the commissioners of Children and Families, Transportation, and Motor Vehicles or their designees;
3. the CHRO executive director or his designee;

4. a Board of Firearms Permit Examiners' member;
5. a member of the Connecticut Bar Association designated by the Association's president;
6. a member of the Permanent Commission on the Status of Women appointed by the Senate president pro tempore; and
7. a legislator with recognized leadership on issues of particular concern to racial minorities in the state appointed by the House speaker or the legislator's designee.

The taskforce has three chairpersons; two selected jointly by the House speaker and Senate president pro tempore from among the task force members and the Office of Policy and Management's secretary or his designee.

The task force must make recommendations to the General Assembly by February 1, 2010 on:

1. the viability of placing the division within CHRO;
2. the scope of matters it will hear;
3. any federal considerations or restrictions, including funding issues related to hearing cases from the departments of Motor Vehicles, Transportation, and Children and Families;
4. the need to train administrative law adjudicators (ALA) in all matters and areas of the law to be heard by the division;
5. the requisite number of ALAs necessary to hear matters assigned to the division and the concomitant level of support staff;
6. procedures for appointing the chief ALA;
7. the transfer of state agency affirmative action plan responsibilities from the CHRO to DAS; and
8. the transfer of contractor affirmative action plan compliance responsibilities from CHRO to the Office of the Attorney General.

EFFECTIVE DATE: Upon passage

## **§ 177 — FOOD DISTRIBUTION AT NONCOMMERCIAL FUNCTIONS**

Existing law allows the sale of food at a noncommercial function such as an educational, religious, political, or charitable organization's bake sale or potluck supper if the food seller maintains it under the temperature, pH level, and water activity level conditions that will inhibit the rapid and progressive growth of infectious or toxigenic microorganisms. A “noncommercial function” is one where food is sold by a person not regularly engaged in the food selling business.

The bill additionally allows for the distribution, as well as the sale, of food at such noncommercial functions. It redefines “noncommercial function” as a function where (1) food is distributed or sold and (2) the seller or distributor is not regularly engaged in the for-profit food business.

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Public Act 09-3, SSS

SB 2051

*Implementing The Provisions Of The Budget Concerning Public Health And Making Changes To Various Health Statutes*

Effective: Upon Passage

### **SUMMARY:**

#### **§§ 1-38 — MERGER OF OHCA WITH DPH**

The bill makes a number of changes, primarily technical, to merge the existing Office of Health Care Access (OHCA) with the Department of Public Health (DPH). It establishes an OHCA division, within DPH and under the direction of the DPH commissioner, as a successor to the former OHCA. OHCA would no longer have its own commissioner.

The bill establishes a deputy commissioner position to oversee the OHCA division of DPH. The bill specifies that the current OHCA commissioner serves as this new deputy commissioner and can exercise independent decision making authority over all certificate of need (CON)-related matters including CON determinations, orders, decisions, and agreed settlements. She is also authorized to designate an

executive assistant. By January 1, 2010, this deputy commissioner, in consultation with the DPH commissioner, must report to the governor and the Public Health Committee on recommendations for CON reform.

The bill specifies that any order, decision, agreed settlement, or regulation of OHCA in force as of the bill's passage, continues in force and effect as a DPH order or regulation until amended, repealed, or superseded by law.

Hospitals are currently assessed to fund OHCA. Under the bill, hospitals must make these payments to DPH instead of OHCA. As under current law, they are deposited in the General Fund.

OHCA's current responsibilities, including health care facility utilization and planning, certificate of need review, hospital charges and payments, data filings, and adoption of regulations, continue under the bill.

#### **§§ 39-41 — LOCAL HEALTH DEPARTMENT FUNDING**

The bill changes the requirements that municipal and district departments of health must meet in order to receive state funding. It eliminates funding for part-time health departments, reduces funding for district health departments, and maintains funding (\$ 1. 18 per capita) for full-time municipal health departments.

The bill adds a requirement that a municipality with a full-time health department have a population of at least 50,000 in order to annual receive funding from the state. Existing requirements for municipal health departments, unchanged by the bill, require the municipality to (1) employ a full-time health director, (2) have a public health program and budget approved by DPH, and (3) appropriate at least \$ 1 per capita from annual tax receipts for health department services.

Also under current law, district health departments receive annual state funding of (1) \$ 2. 43 per capita for each city, town, and borough in the district with a population of 5,000 or less and (2) \$ 2. 08 per capita for each such jurisdiction with a population over 5,000. The bill requires a health district to have a total population of at least 50,000 or serve three or more municipalities regardless of their combined total population in order to receive state funding. It reduces district funding to \$ 1. 85 per capita.

EFFECTIVE DATE: July 1, 2009

## **§§ 42, 62 — MANAGED RESIDENTIAL COMMUNITIES**

The bill eliminates (1) the requirement that managed residential communities (MRCs) be subject to DPH oversight and regulation and (2) DPH's responsibility to investigate complaints about MRC violations of the law and review every MRC's operations every two years. But it retains DPH's authority to adopt regulations governing MRCs. MRCs are facilities that provide housing and services for people over age 55, including access to assisted living services.

## **§§ 43, 59 — SUSTINET**

### ***Board Membership***

The bill increases membership on the SustiNet Health Partnership board of directors from nine to eleven by adding (1) an individual with expertise in either the reduction of racial, ethnic, cultural and linguistic inequities in health care or multi-cultural competency in the health care workforce, appointed by the Healthcare Advocate and (2) an individual appointed by the Comptroller.

The healthcare advocate and comptroller must make their appointments within 30 days of the bill's passage. The initial term for these new board members is five years. The bill also increases the number of board members necessary for a quorum from five to six.

### ***Funding Sources***

Under existing law, the board must offer recommendations to the General Assembly on the structure of the entity best suited to oversee and implement the SustiNet Plan. These recommendations can include the creation of a public authority authorized, among other things, to raise funds from private and public sources outside of the state budget to contribute toward support of its mission and operations.

The bill specifies that this includes applying for and receiving federal funds.

## **§§ 44-46 — BIRTH-TO-THREE FEE AND INSURANCE INCREASES**

The bill increases the fee certain families must pay to participate in the Birth-to-Three program and eliminates the two months of service following enrollment that, by regulation, are currently provided

without a fee. It requires the Department of Developmental Services (DDS) to increase the fees by 60%. It also requires DDS to base the fees on the state's, as well as parents', financial resources and periodically to revise its fee schedule.

The law requires DDS to charge a fee for families with gross incomes over \$ 45,000 and permits it to charge parents with lower incomes. But it may not charge any family whose child is eligible for Medicaid. DDS maintains two sliding scale fee schedules, one for families with health insurance and one for uninsured families, based on income and family size. Fees currently range from \$ 15 a month for a family with three or fewer children and no insurance to \$ 310 a month for a family with six or more children and insurance whose income is over \$ 175,000. DDS regulations require the State Interagency Birth to Three Coordinating Council to review and make recommendations to DDS about the fee schedule at least every three years.

The law requires group and individual health insurance policies to cover Birth-to-Three services. The bill doubles the maximum annual coverage to \$ 6,400 per child and the aggregate, lifetime benefit to \$ 19,200. It 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; and (4) hospital or medical services, including coverage under an HMO plan. Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

## **§§ 47-49 — SEXUAL ASSAULT FORENSIC EXAMINERS**

### ***Sexual Assault Forensic Examiners Program***

The bill authorizes the Office of Victim Services (OVS) to establish a program to train sexual assault forensic examiners (SAFE) and make them available to adult and adolescent sexual assault victims at participating hospitals. It bill allows OVS to apply for and use funds from federal, state, and private sources for the program.

The bill requires a SAFE to be a physician or a registered or advanced practice registered nurse. Under the bill, a SAFE may provide immediate care and treatment to a sexual assault victim in a hospital and collect evidence. In doing so, the SAFE must follow (1) existing state sexual assault evidence collection protocols, (2) the hospital's policies

and accreditation standards, and (3) the hospital's written agreement with OVS and DPH concerning its participation in the SAFE program.

The bill specifies that it is not to be construed to alter the scope of nursing practice established in statute.

### ***Sexual Assault Forensic Examiners Advisory Committee***

The bill creates a 12-member committee to advise OVS on establishing and implementing the program.

***Responsibilities.*** The committee must make recommendations to OVS on:

1. recruiting participants and developing a specialized training course for them;
2. developing agreements between Judicial Branch, the Public Health Department (DPH), and participating hospitals on the program's scope of services and hospital standards for providing the services;
3. mechanisms for tracking individual cases;
4. using medically accepted best practices; and
5. developing quality assurance mechanisms.

***Membership.*** The committee consists of:

1. the chief court administrator, chief state's attorney, victim advocate, and DPH commissioner, or their designees;
2. one representative each of the Public Safety Department's Scientific Services and State Police divisions, appointed by the public safety commissioner;
3. the presidents of the Connecticut Hospital Association and Connecticut College of Emergency Physicians, or their designees;
4. a person appointed by the directors of Connecticut Sexual Assault Crisis Services, Inc. ;

5. one appointee each from the Connecticut Chapter of the International Association of Forensic Nurses, the Connecticut Police Chiefs Association, and the Connecticut Emergency Nurses Association.

The committee terminates on June 30, 2012.

### **§§ 51-52 — PAYMENT FOR TUBERCULOSIS TREATMENT**

Under current law, individuals with tuberculosis (TB) who requires medical care provided by (1) a state chronic disease hospital, (2) a private hospital or clinic, or (3) a physician or other provider, must be seen without regard to the patient's financial condition. The cost of the care and treatment of such patients is computed based on a number of statutory provisions. The state pays these costs if DPH deems them appropriate for TB treatment.

The bill specifically authorizes the DPH commissioner to consider available third- party sources for payment of TB treatment when determining whether to pay for it. By law, if the patient is (1) a veteran and the TB or suspected TB for which the veteran has been hospitalized or treated is a service-connected disability entitling him to medical benefits or (2) eligible for medical benefits under the workers' compensation law or under any private or public medical insurance or payment plan, then the patient or the patient's obligor is liable for the costs of the care to the extent of such available benefits. The costs of such care must be determined according to the existing statutory process by which the comptroller annually determines the per capita per diem cost for the support of persons in humane institutions.

The bill authorizes DPH and DSS to exchange patient information they hold to determine if any patient needing or receiving TB treatment is eligible for Medicaid benefits.

### **§ 58 — HEALTH CARE PROVIDER PEER REVIEW CONFIDENTIALITY**

The bill specifies that materials or information produced for peer review purposes, in any format or media, are not subject to disclosure under the Freedom of Information Act (FOIA).

By law, “peer review” means the procedure for evaluation by health care professionals of the quality and effectiveness of services ordered or

performed by other health care professionals. This includes practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review.

The bill specifies that it does not preclude DPH from accessing peer review materials and information in connection with any department review or investigation of a provider's license. But DPH may not disclose the information to any person outside of the agency, except as necessary to take disciplinary action against the provider, and the information cannot be disclosed under FOIA. The bill also specifies that it does not limit other protections on peer review provided by law.

### ***Background***

The Connecticut Supreme Court recently held that records of a public hospital that would be privileged from discovery under Connecticut's peer review statute are subject to disclosure pursuant to proceedings before the state's Freedom of Information Commission (*Director of Health Affairs Policy Planning, University of Connecticut Health Center v. Freedom of Information Commission*, Conn. , No. SC 18286, August 25, 2009).

### **§ 61 — REPEALED SECTIONS**

The bill repeals obsolete OHCA statutes, a section on TB treatment payment for consistency with new language in the bill, and provisions related to DPH responsibilities concerning managed residential care communities (see § 43).

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Public Act 09-8, SSS

SB 2052

### ***Implementing The Provisions Of The Budget Concerning Revenue***

Effective: Upon Passage

### **SUMMARY:**

### **§ 18 – License Fee Increase for Certain Cigarette Distributors**

### **OFA Fiscal Impact**

The bill implements the revenue estimates adopted by the Finance, Revenue, and Bonding Committee on October 2, 2009 by including a fee that were inadvertently omitted from PA 09-3 (JSS).

### **OLR Analysis**

The bill increases the annual fee for a DRS license as a “non-exclusive” cigarette distributor (a distributor who does not sell cigarettes exclusively to retail stores) from \$ 1,000 to \$ 1,250. This matches the license fee increase in PA 09-3, June Special Session, for a cigarette distributor who sells to more than 25 retail stores.

EFFECTIVE DATE: Upon passage and applicable to renewal of licenses expiring on or after September 30, 2009.

### **§ 19 – Applicability of Increased Licenses Fees**

#### **OFA Fiscal Impact**

The bill clarifies the applicability of the fee increases included in PA 09-3 (JSS), which has no fiscal impact.

### **OLR Analysis**

With the exception of several cigarette licenses issued by DRS, the bill makes the increases in license renewal fees enacted in PA 09-3, June Special Session apply only to the renewal of licenses that expire on or after October 1, 2009.

The bill does not apply to increased DRS fees for:

1. cigarette manufacturer's licenses and duplicate copies;
2. a cigarette dealer's licenses and duplicate copies; and
3. licenses for cigarette distributors with (a) fewer than 15 stores, (b) 15 to 24 stores, and (c) 25 or more stores.

EFFECTIVE DATE: Upon passage

### **§ 20 – Licensed Practical Nurse License Fee**

#### **OFA Fiscal Impact**

The bill is anticipated to result in a General Fund revenue gain of \$ 400,000 per year beginning in FY 10.

**OLR Analysis**

The bill reverses an increase in the annual license fee for a licensed practical nurse. PA 09-3, June Special Session, doubled the fee from \$ 60 to \$ 120, effective October 1, 2009. This bill restores the \$ 60 fee.

EFFECTIVE DATE: Upon passage

**§§ 23-27 – Department of Public Health Fees**

**OFA Fiscal Impact**

The bill implements the revenue estimates adopted by the Finance, Revenue, and Bonding Committee on October 2, 2009.

**OLR Analysis**

The bill increases the Department of Public Health fees shown in Table 1.

**Table 1: Department of Public Health Fee Increases**

<b>Bill §</b>	<b>CGS §</b>	<b>Fee Description</b>	<b>Current</b>	<b>Proposed</b>
23	20-341g	Subsurface sewage disposal system installer license - annual renewal	\$ 25	\$ 50
23	20-341g	Subsurface sewage disposal system cleaner license - annual renewal	10	20
24	20-438	Asbestos abatement site supervisor's certificate -application	50	100
24	20-438	Asbestos abatement site supervisor's certificate - annual renewal	50	100
25	20-162bb (b)	Perfusionist license - application fee	250	315
26	20-162bb (g)	Perfusionist license - annual renewal	250	315
27	PA 09-232, § 56 (a)	Audiologist - initial license fee and annual renewal	100	200

EFFECTIVE DATE: Upon passage and applicable to renewal of a license expiring on or after October 1, 2009.

Implementing The Provisions Of The Budget Concerning Education,  
Authorizing State Grant Commitments For School Building Projects, And  
Making Changes To The Statutes Concerning School Building Projects And  
Other Education Statutes

Effective: Upon Passage

**SUMMARY:**

**§§ 50 & 51 — EARLY CHILDHOOD EDUCATION CABINET**

The bill reconstitutes the existing Early Childhood Education Cabinet and changes its membership and duties. Some of its duties under current law are given to the Early Childhood Planning Office, some are eliminated, and some remain with the cabinet.

The new 17-member cabinet will include the following commissioners, or their respective designees: (1) education, (2) social services, (3) public health, (4) developmental services, and (5) mental health and addiction services.

The cabinet also includes:

1. the Office of Policy and Management secretary or his representative;
2. a SDE representative who is responsible for special education programs;
3. a representative from an institution of higher education appointed by the higher education commissioner;
4. the Commission on Children executive director, or her designee;
5. the Connecticut Head Start State Collaboration Office project director;
6. a Head Start Program representative appointed by the House minority leader;

7. a local provider of early childhood education appointed by the Senate minority leader;
8. a member of the House appointed by the House speaker;
9. a parent who has a child attending school in a priority school district who is appointed by the House speaker;
10. a member of the Senate appointed by the Senate president pro tempore;
11. a representative of a public elementary school with a prekindergarten program appointed by the Senate president pro tempore; and
12. a representative of the business or philanthropic community appointed by the governor.

The chairperson of the new cabinet must be appointed by the governor from among the members.

Under current law, the existing cabinet is comprised of many of the same members, or their representatives, but the following are not part of the cabinet under the bill:

1. the governor or her representative,
2. the higher education commissioner, or his representative;
3. the children and families commissioner, or her representative,
4. the co-chairs of the education and human services committees;
5. a representative of a local or regional school readiness council appointed by the Senate president pro tempore;
6. a representative of the Connecticut Head Start Association appointed by the House speaker.

Although the higher education commissioner is not a member of the cabinet, under the bill he appoints the member who represents higher education on the cabinet. Also, while the co-chairs of the two legislative

committees are not named, the leaders of the house and senate each appoint a member of their respective chambers to the cabinet.

### ***Duties***

Under the bill, the cabinet must:

1. coordinate the development of services that enhance the health, safety, and learning of children from birth to nine among state agencies and public and private partnerships;
2. annually by December 1, 2009, develop a plan of action that assigns the appropriate state agency to complete the tasks specified in the federal Head Start Act (P. L. 110-134); and
3. annually by March 1, 2010, submit a state-wide strategic report, pursuant to the federal Head Start Act to the General Assembly and the governor addressing the progress the agencies have made toward the completion of (1) the tasks outlined under said federal Head Start Act and (2) the aforementioned duties under this bill.

The cabinet will operate within available appropriations and any private funding that may be available. It will be located within the SDE for administrative purposes.

Under the bill, the cabinet would no longer be charged with the following duties:

1. performing a statewide longitudinal evaluation of school readiness programs (the bill designates this to the early childhood planning office);
2. developing and implementing an annual accountability plan (bill designates this to early childhood planning office);
3. advising the education commissioner on policies to meet the school readiness goals;
4. developing budget requests for the early childhood programs;
5. promoting the consistency of quality and comprehensiveness of early childhood services;

6. developing minimum quality standards and a range of higher quality standards for all early care and education programs receiving state funding and annually reporting to the General Assembly on such standards; and

7. developing, with Office of Workforce Competitiveness, a school readiness workforce development plan and reporting annually to the General Assembly on the plan.

Also the bill eliminates the requirement that early childhood education providers that receive state funding report annually to the cabinet on the effectiveness of the provider's services.

### ***School Readiness Program Agreement***

By law, the education and social service commissioners must develop an agreement to define the duties and responsibilities of their departments concerning school readiness programs. The bill requires the agreement to be submitted on or before January 1, 2010, and annually thereafter, to the cabinet and the Education and Human Services committees. Under current law the commissioners must consult the cabinet in developing the agreement. The bill removes that requirement.