General Assembly

Amendment

January Session, 2021

LCO No. **8605**

Offered by:
SEN. DAUGHERTY ABRAMS, 13th Dist.
REP. STEINBERG, 136th Dist.

To: Senate Bill No. **1070** File No. 536 Cal. No. 317

"AN ACT ALLOWING ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS TO ISSUE HOME HEALTH ORDERS."

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

"Section 1. Section 20-12c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Each physician assistant practicing in this state or participating in a resident physician assistant program shall have a clearly identified supervising physician who maintains the final responsibility for the care of patients and the performance of the physician assistant.

(b) A physician may function as a supervising physician for as many physician assistants as is medically appropriate under the circumstances, provided the supervision is active and direct.

(c) Nothing in this chapter shall be construed to prohibit the

employment of a physician **[**assistants**]** assistant in a hospital or other health care facility where such physician **[**assistants function**]** assistant functions under the direction of a supervising physician.

(d) Nothing in this chapter shall be construed to prohibit a licensed physician assistant who is (1) part of the Connecticut Disaster Medical Assistance Team or the Medical Reserve Corps, under the auspices of the Department of Public Health, or the Connecticut Urban Search and Rescue Team, under the auspices of the Department of Emergency Services and Public Protection, and is engaged in officially authorized civil preparedness duty or civil preparedness training conducted by such team or corps, or (2) licensed in another state as a physician assistant or its equivalent and is an active member of the Connecticut Army or Air National Guard, from providing patient services under the supervision, control, responsibility and direction of a licensed physician.

Sec. 2. Subdivision (5) of section 3-39j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(5) "Disability certification" means, with respect to an individual, a certification to the satisfaction of the Secretary of the Treasury of the United States by the individual or the parent or guardian of the individual that (A) certifies that (i) the individual has a medically determinable physical or mental impairment, that results in marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months, or is blind within the meaning of Section 1614(a)(2) of the Social Security Act, and (ii) such impairment or blindness occurred before the date on which the individual attained the age of twenty-six, and (B) includes a copy of the individual's diagnosis relating to the individual's relevant impairment or blindness that is signed by a physician who is licensed pursuant to chapter 370 or, to the extent permitted by federal law, (i) an advanced practice registered nurse who is licensed pursuant to chapter 378, **[**or**]** (ii) a physician

assistant who is licensed pursuant to chapter 370, or (iii) if the individual's impairment is blindness, an optometrist licensed pursuant to chapter 380.

Sec. 3. Subsection (b) of section 3-123aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) There is established the Connecticut Homecare Option Program for the Elderly, to allow individuals to plan for the cost of services that will allow them to remain in their homes or in a noninstitutional setting as they age. The Comptroller shall establish the Connecticut Home Care Trust Fund, which shall be comprised of individual savings accounts for those qualified home care expenses not covered by a long-term care insurance policy and for those qualified home care expenses that supplement the coverage provided by a long-term care policy or Medicare. Withdrawals from the fund may be used for qualified home care expenses, upon receipt by the fund of a certification signed by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse that the designated beneficiary is in need of services for the instrumental activities of daily living. Upon the death of a designated beneficiary, any available funds in such beneficiary's account shall be an asset of the estate of such beneficiary.

Sec. 4. Subdivision (16) of section 10-183b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(16) "Formal application of retirement" means the member's application, birth certificate or notarized statement supported by other evidence satisfactory to the board, in lieu thereof, records of service when required by the board to determine a salary rate or years of creditable service, statement of payment plan and, in the case of an application for a disability benefit, a physician's, a physician assistant's or an advanced practice registered nurse's statement of health.

Sec. 5. Subsection (a) of section 10a-155 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Each institution of higher education shall require each full-time or matriculating student born after December 31, 1956, to provide proof of adequate immunization against measles, rubella and on and after August 1, 2010, to provide proof of adequate immunization against mumps and varicella as recommended by the national Advisory Committee for Immunization Practices before permitting such student to enroll in such institution. Any such student who (1) presents a certificate from a physician, a physician assistant or an advanced practice registered nurse stating that in the opinion of such physician, physician assistant or advanced practice registered nurse such immunization is medically contraindicated, (2) provides a statement that such immunization would be contrary to his religious beliefs, (3) presents a certificate from a physician, a physician assistant, an advanced practice registered nurse or the director of health in the student's present or previous town of residence, stating that the student has had a confirmed case of such disease, (4) is enrolled exclusively in a program for which students do not congregate on campus for classes or to participate in institutional-sponsored events, such as students enrolled in distance learning programs for individualized home study or programs conducted entirely through electronic media in a setting without other students present, or (5) graduated from a public or nonpublic high school in this state in 1999 or later and was not exempt from the measles, rubella and on and after August 1, 2010, the mumps vaccination requirement pursuant to subdivision (2) or (3) of subsection (a) of section 10-204a shall be exempt from the appropriate provisions of this section.

Sec. 6. Section 10a-155a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

When a public health official has reason to believe that the continued presence in an institution of higher education of a student who has not been immunized against measles or rubella presents a clear danger to

the health of others, the public health official shall notify the chief administrative officer of such institution. Such chief administrative officer shall cause the student to be excluded from the institution, or confined in an infirmary or other medical facility at the institution, until the student presents to such chief administrative officer a certificate from a physician, a physician assistant or an advanced practice registered nurse stating that, in the opinion of such physician, physician assistant or advanced practice registered nurse, the presence in the institution of the student does not present a clear danger to the health of others.

Sec. 7. Section 12-94 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

The exemptions granted in sections 12-81 and 12-82 to soldiers, sailors, marines and members of the Coast Guard and Air Force, and their spouses, widows, widowers, fathers and mothers, and to blind or totally disabled persons and their spouses shall first be made in the town in which the person entitled thereto resides, and any person asking such exemption in any other town shall annually make oath before, or forward his or her affidavit to, the assessors of such town, deposing that such exemptions, except the exemption provided in subdivision (55) of section 12-81, if allowed, will not, together with any other exemptions granted under sections 12-81 and 12-82, exceed the amount of exemption thereby allowed to such person. Such affidavit shall be filed with the assessors within the period the assessors have to complete their duties in the town where the exemption is claimed. The assessors of each town shall annually make a certified list of all persons who are found to be entitled to exemption under the provisions of said sections, which list shall be filed in the town clerk's office, and shall be prima facie evidence that the persons whose names appear thereon and who are not required by law to give annual proof are entitled to such exemption as long as they continue to reside in such town; but such assessors may, at any time, require any such person to appear before them for the purpose of furnishing additional evidence, provided, any person who by reason of such person's disability is unable to so appear may furnish such

assessors a statement from such person's attending physician, physician assistant or an advanced practice registered nurse certifying that such person is totally disabled and is unable to make a personal appearance and such other evidence of total disability as such assessors may deem appropriate.

Sec. 8. Subsection (a) of section 12-129c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) No claim shall be accepted under section 12-129b unless the taxpayer or authorized agent of such taxpayer files an application with the assessor of the municipality in which the property is located, in affidavit form as provided by the Secretary of the Office of Policy and Management, during the period from February first to and including May fifteenth of any year in which benefits are first claimed, including such information as is necessary to substantiate said claim in accordance with requirements in such application. A taxpayer may make application to the secretary prior to August fifteenth of the claim year for an extension of the application period. The secretary may grant such extension in the case of extenuating circumstance due to illness or incapacitation as evidenced by a certificate signed by a physician, a physician assistant or an advanced practice registered nurse to that extent, or if the secretary determines there is good cause for doing so. The taxpayer shall present to the assessor a copy of such taxpayer's federal income tax return and the federal income tax return of such taxpayer's spouse, if filed separately, for such taxpayer's taxable year ending immediately prior to the submission of the taxpayer's application, or if not required to file a federal income tax return, such other evidence of qualifying income in respect to such taxable year as the assessor may require. Each such application, together with the federal income tax return and any other information submitted in relation thereto, shall be examined by the assessor and if the application is approved by the assessor, it shall be forwarded to the secretary on or before July first of the year in which such application is approved, except that in the case of a taxpayer who received a filing date extension

from the secretary, such application shall be forwarded to the secretary not later than ten business days after the date it is filed with the assessor. After a taxpayer's claim for the first year has been filed and approved such taxpayer shall be required to file such an application biennially. In respect to such application required after the filing and approval for the first year the tax assessor in each municipality shall notify each such taxpayer concerning application requirements by regular mail not later than February first of the assessment year in which such taxpayer is required to reapply, enclosing a copy of the required application form. Such taxpayer may submit such application to the assessor by mail, provided it is received by the assessor not later than April fifteenth in the assessment year with respect to which such tax relief is claimed. Not later than April thirtieth of such year the assessor shall notify, by mail evidenced by a certificate of mailing, any such taxpayer for whom such application was not received by said April fifteenth concerning application requirements and such taxpayer shall be required not later than May fifteenth to submit such application personally or for reasonable cause, by a person acting on behalf of such taxpayer as approved by the assessor.

Sec. 9. Subsection (f) of section 12-170aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) Any homeowner, believing such homeowner is entitled to tax reduction benefits under this section for any assessment year, shall make application as required in subsection (e) of this section, to the assessor of the municipality in which the homeowner resides, for such tax reduction at any time from February first to and including May fifteenth of the year in which tax reduction is claimed. A homeowner may make application to the secretary prior to August fifteenth of the claim year for an extension of the application period. The secretary may grant such extension in the case of extenuating circumstance due to illness or incapacitation as evidenced by a certificate signed by a physician<u>, physician assistant</u> or an advanced practice registered nurse to that extent, or if the secretary determines there is good cause for doing

so. Such application for tax reduction benefits shall be submitted on a form prescribed and furnished by the secretary to the assessor. In making application the homeowner shall present to such assessor, in substantiation of such homeowner's application, a copy of such homeowner's federal income tax return, including a copy of the Social Security statement of earnings for such homeowner, and that of such homeowner's spouse, if filed separately, for such homeowner's taxable year ending immediately prior to the submission of such application, or if not required to file a return, such other evidence of qualifying income in respect to such taxable year as may be required by the assessor. When the assessor is satisfied that the applying homeowner is entitled to tax reduction in accordance with this section, such assessor shall issue a certificate of credit, in such form as the secretary may prescribe and supply showing the amount of tax reduction allowed. A duplicate of such certificate shall be delivered to the applicant and the tax collector of the municipality and the assessor shall keep the fourth copy of such certificate and a copy of the application. Any homeowner who, for the purpose of obtaining a tax reduction under this section, wilfully fails to disclose all matters related thereto or with intent to defraud makes false statement shall refund all property tax credits improperly taken and shall be fined not more than five hundred dollars. Applications filed under this section shall not be open for public inspection.

Sec. 10. Subsection (a) of section 12-170f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Any renter, believing himself or herself to be entitled to a grant under section 12-170d for any calendar year, shall apply for such grant to the assessor of the municipality in which the renter resides or to the duly authorized agent of such assessor or municipality on or after April first and not later than October first of each year with respect to such grant for the calendar year preceding each such year, on a form prescribed and furnished by the Secretary of the Office of Policy and Management to the assessor. A renter may apply to the secretary prior to December fifteenth of the claim year for an extension of the

application period. The secretary may grant such extension in the case of extenuating circumstance due to illness or incapacitation as evidenced by a certificate signed by a physician, physician assistant or an advanced practice registered nurse to that extent, or if the secretary determines there is good cause for doing so. A renter making such application shall present to such assessor or agent, in substantiation of the renter's application, a copy of the renter's federal income tax return, and if not required to file a federal income tax return, such other evidence of qualifying income, receipts for money received, or cancelled checks, or copies thereof, and any other evidence the assessor or such agent may require. When the assessor or agent is satisfied that the applying renter is entitled to a grant, such assessor or agent shall issue a certificate of grant in such form as the secretary may prescribe and supply showing the amount of the grant due.

Sec. 11. Subsection (a) of section 12-170w of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) No claim shall be accepted under section 12-170v unless the taxpayer or authorized agent of such taxpayer files an application with the assessor of the municipality in which the property is located, in such form and manner as the assessor may prescribe, during the period from February first to and including May fifteenth of any year in which benefits are first claimed, including such information as is necessary to substantiate such claim in accordance with requirements in such application. A taxpayer may make application to the assessor prior to August fifteenth of the claim year for an extension of the application period. The assessor may grant such extension in the case of extenuating circumstance due to illness or incapacitation as evidenced by a certificate signed by a physician, a physician assistant or an advanced practice registered nurse to that extent, or if the assessor determines there is good cause for doing so. The taxpayer shall present to the assessor a copy of such taxpayer's federal income tax return and the federal income tax return of such taxpayer's spouse, if filed separately, for such taxpayer's taxable year ending immediately prior to the

submission of the taxpayer's application, or if not required to file a federal income tax return, such other evidence of qualifying income in respect to such taxable year as the assessor may require. Each such application, together with the federal income tax return and any other information submitted in relation thereto, shall be examined by the assessor and a determination shall be made as to whether the application is approved. Upon determination by the assessor that the applying homeowner is entitled to tax relief in accordance with the provisions of section 12-170v and this section, the assessor shall notify the homeowner and the municipal tax collector of the approval of such application. The municipal tax collector shall determine the maximum amount of the tax due with respect to such homeowner's residence and thereafter the property tax with respect to such homeowner's residence shall not exceed such amount. After a taxpayer's claim for the first year has been filed and approved such taxpayer shall file such an application biennially. In respect to such application required after the filing and approval for the first year the assessor in each municipality shall notify each such taxpayer concerning application requirements by regular mail not later than February first of the assessment year in which such taxpayer is required to reapply, enclosing a copy of the required application form. Such taxpayer may submit such application to the assessor by mail, provided it is received by the assessor not later than April fifteenth in the assessment year with respect to which such tax relief is claimed. Not later than April thirtieth of such year the assessor shall notify, by mail evidenced by a certificate of mailing, any such taxpayer for whom such application was not received by said April fifteenth concerning application requirements and such taxpayer shall submit not later than May fifteenth such application personally or for reasonable cause, by a person acting on behalf of such taxpayer as approved by the assessor.

Sec. 12. Subsection (b) of section 14-73 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) Application for an instructor's license shall be in writing and shall

contain such information as the commissioner requires. Each applicant for a license shall be fingerprinted and shall furnish evidence satisfactory to the commissioner that such applicant (1) is of good moral character considering such person's state and national criminal history records checks conducted in accordance with section 29-17a, and record, if any, on the state child abuse and neglect registry established pursuant to section 17a-101k. If any applicant for a license or the renewal of a license has a criminal record or is listed on the state child abuse and neglect registry, the commissioner shall make a determination of whether to issue or renew an instructor's license in accordance with the standards and procedures set forth in section 14-44 and the regulations adopted pursuant to said section; (2) has held a license to drive a motor vehicle for the past four consecutive years and has a driving record satisfactory to the commissioner, including no record of a conviction or administrative license suspension for a drug or alcohol-related offense during such four-year period; (3) has had a recent medical examination by a physician, physician assistant or an advanced practice registered nurse licensed to practice within the state and the physician, physician assistant or advanced practice registered nurse certifies that the applicant is physically fit to operate a motor vehicle and instruct in driving; (4) has received a high school diploma or has an equivalent academic education; and (5) has completed an instructor training course of forty-five clock hours given by a school or agency approved by the commissioner, except that any such course given by an institution under the jurisdiction of the board of trustees of the Connecticut State University System shall be approved by the commissioner and the State Board of Education. During the period of licensure, an instructor shall notify the commissioner, within forty-eight hours, of an arrest or conviction for a misdemeanor or felony, or an arrest, conviction or administrative license suspension for a drug or alcohol-related offense.

Sec. 13. Subdivision (2) of subsection (c) of section 14-100a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(2) The provisions of subdivision (1) of this subsection shall not apply

to (A) any person whose physical disability or impairment would prevent restraint in such safety belt, provided such person obtains a written statement from a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse containing reasons for such person's inability to wear such safety belt and including information concerning the nature and extent of such condition. Such person shall carry the statement on his or her person or in the motor vehicle at all times when it is being operated, or (B) an authorized emergency vehicle, other than fire fighting apparatus, responding to an emergency call or a motor vehicle operated by a rural letter carrier of the United States postal service while performing his or her official duties or by a person engaged in the delivery of newspapers.

Sec. 14. Subsection (c) of section 14-286 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) (1) The Commissioner of Motor Vehicles may issue to a person who does not hold a valid operator's license a special permit that authorizes such person to ride a motor-driven cycle if (A) such person presents to the commissioner a certificate by a physician licensed to practice medicine in this state, a physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 that such person is physically disabled, as defined in section 1-1f, other than blind, and that, in the physician's, physician assistant's or advanced practice registered nurse's opinion, such person is capable of riding a motor-driven cycle, and (B) such person demonstrates to the Commissioner of Motor Vehicles that he is able to ride a bicycle on level terrain, and a motor-driven cycle. (2) Such permit may contain limitations that the commissioner deems advisable for the safety of such person and for the public safety, including, but not limited to, the maximum speed of the motor such person may use. No person who holds a valid special permit under this subsection shall operate a motor-driven cycle in violation of any limitations imposed in the permit. Any person to whom a special permit is issued shall carry the permit at all times while operating the motor-driven cycle. Each

permit issued under this subsection shall expire one year from the date of issuance.

Sec. 15. Subsection (a) of section 14-314c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) The Office of the State Traffic Administration, on any state highway, or a local traffic authority, on any highway under its control, shall, upon receipt of an application on behalf of any person under the age of eighteen who is deaf, as certified by a physician, a physician assistant or an advanced practice registered nurse, erect one or more signs in the person's neighborhood to warn motor vehicle operators of the presence of such person.

Sec. 16. Subdivision (1) of subsection (b) of section 16-262c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) (1) From November first to May first, inclusive, no electric distribution company, as defined in section 16-1, no electric supplier and no municipal utility furnishing electricity shall terminate, deny or refuse to reinstate residential electric service in hardship cases where the customer lacks the financial resources to pay his or her entire account. From November first to May first, inclusive, no gas company and no municipal utility furnishing gas shall terminate, deny or refuse to reinstate residential gas service in hardship cases where the customer uses such gas for heat and lacks the financial resources to pay his or her entire account, except a gas company that, between May second and October thirty-first, terminated gas service to a residential customer who uses gas for heat and who, during the previous period of November first to May first, had gas service maintained because of hardship status, may refuse to reinstate the gas service from November first to May first, inclusive, only if the customer has failed to pay, since the preceding November first, the lesser of: (A) Twenty per cent of the outstanding principal balance owed the gas company as of the date of

termination, (B) one hundred dollars, or (C) the minimum payments due under the customer's amortization agreement. Notwithstanding any other provision of the general statutes to the contrary, no electric distribution or gas company, no electric supplier and no municipal utility furnishing electricity or gas shall terminate, deny or refuse to reinstate residential electric or gas service where the customer lacks the financial resources to pay his or her entire account and for which customer or a member of the customer's household the termination, denial of or failure to reinstate such service would create a life-threatening situation. No electric distribution or gas company, no electric supplier and no municipal utility furnishing electricity or gas shall terminate, deny or refuse to reinstate residential electric or gas service where the customer is a hardship case and lacks the financial resources to pay his or her entire account and a child not more than twenty-four months old resides in the customer's household and such child has been admitted to the hospital and received discharge papers on which the attending physician, physician assistant or an advanced practice registered nurse has indicated such service is a necessity for the health and well-being of such child.

Sec. 17. Subsection (b) of section 16-262d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) No such company, electric supplier or municipal utility shall effect termination of service for nonpayment during such time as any resident of a dwelling to which such service is furnished is seriously ill, if the fact of such serious illness is certified to such company, electric supplier or municipal utility by a registered physician, a physician assistant or an advanced practice registered nurse within such period of time after the mailing of a termination notice pursuant to subsection (a) of this section as the Public Utilities Regulatory Authority may by regulation establish, provided the customer agrees to amortize the unpaid balance of his account over a reasonable period of time and keeps current his account for utility service as charges accrue in each subsequent billing period.

Sec. 18. Subsection (a) of section 17a-81 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Parental consent shall be necessary for treatment. In the event such consent is withheld or immediately unavailable and the physician, physician assistant or advanced practice registered nurse certified as a psychiatric mental health provider by the American Nurses Credentialing Center concludes that treatment is necessary to prevent serious harm to the child, such emergency treatment may be administered pending receipt of parental consent.

Sec. 19. Section 17b-233 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Newington Children's Hospital may admit any child who is handicapped or afflicted with any pediatric illness upon application of the selectmen of any town, or the guardian or any relative of such child, or any public health agency, physician, physician assistant or advanced practice registered nurse, provided, no person shall be admitted primarily for the treatment of any drug-related condition. Said hospital shall admit such child to said hospital if such child is pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said hospital, after examination, to be suitable for admission, and said hospital shall keep and support such child for such length of time as it deems proper. Said hospital shall not be required to admit any such child unless it can conveniently receive and care for such child at the time application is made and said hospital may return to the town in which such child resides any child so taken who is pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said hospital, after examination, to be unsuitable for retention or who, by reason of improvement in his condition or completion of his treatment or training, ought not to be further retained. The hospital may refuse to admit any child pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said hospital, after examination, to be unsuitable for admission

and may refuse to admit any such child when the facilities at the hospital will not, in the judgment of **[**said**]** such physician, physician assistant or advanced practice registered nurse, permit the hospital to care for such child adequately and properly.

Sec. 20. Section 17b-236 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

When there is found in any town in this state any child of sound mind who is physically disabled or who is afflicted with poliomyelitis or rheumatic fever, or any uncontagious disabling disease, and who is unable to pay and whose relatives who are legally liable for his support are unable to pay the full cost of treating such disease, if such child and one of such relatives reside in this state, the selectmen of such town, or the guardian or any relative of such child, or any public health agency, physician, physician assistant or advanced practice registered nurse in this state, may make application to The Children's Center, located at Hamden, for the admission of such child to said center. Said center shall admit such child if such child is pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said center, after examination, to be fit for admission, and said center shall keep and support such child for such length of time as it deems proper. Said center shall not be required to admit any such child unless it can conveniently receive and care for him at the time such application is made, and said center may return to the town in which such child resides any child so taken who is pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said center, after examination, to be unfit for retention, or who, by reason of improvement in his condition or completion of his treatment or training, ought not to be further retained. The center may refuse to admit any child who is pronounced by a physician, a physician assistant or an advanced practice registered nurse on the staff of said center, after examination, to be unfit for admission, and may refuse to admit any such child when the facilities at the center will not, in the judgment of **[**said**]** such physician, physician assistant or advanced practice registered nurse, permit the center to care for such child adequately and

properly.

Sec. 21. Subsection (f) of section 17b-261p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) (1) A nursing home, on behalf of an applicant, may request an extension of time to claim undue hardship pursuant to subsections (b) and (e) of this section if (A) the applicant is receiving long-term care services in such nursing home, (B) the applicant has no legal representative, and (C) the nursing home provides certification from a physician, a physician assistant or an advanced practice registered nurse that the applicant is incapable of caring for himself or herself, as defined in section 45a-644, or incapable of managing his or her affairs, as defined in section 45a-644. The commissioner shall grant such request to allow a legal representative to be appointed to act on behalf of the applicant.

(2) The commissioner shall accept any claim filed pursuant to subsection (b) of this section by a nursing home and allow the nursing home to represent the applicant with regard to such claim if the applicant or the legal representative of the applicant gives permission to the nursing home to file a claim pursuant to subsection (b) of this section.

Sec. 22. Section 17b-278d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

The Commissioner of Social Services, to the extent permitted by federal law, shall take such action as may be necessary to amend the Medicaid state plan and the state children's health insurance plan to provide coverage without prior authorization for each child diagnosed with cancer on or after January 1, 2000, who is covered under the HUSKY Health program, for neuropsychological testing ordered by a licensed physician, licensed physician assistant or licensed advanced practice registered nurse, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

Sec. 23. Section 18-94 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

When the medical officer of, or any physician, physician assistant or advanced practice registered nurse employed in, any correctional or charitable institution reports in writing to the warden, superintendent or other officer in charge of such institution that any inmate thereof committed thereto by any court or supported therein in whole or in part at public expense is afflicted with any sexually transmitted disease so that such inmate's discharge from such institution would be dangerous to the public health, such inmate shall, with the approval of such warden, superintendent or other officer in charge, be detained in such institution until such medical officer, physician, physician assistant or advanced practice registered nurse reports in writing to the warden, superintendent or officer in charge of such institution that such inmate may be discharged therefrom without danger to the public health. During detention the person so detained shall be supported in the same manner as before such detention.

Sec. 24. Section 19a-2a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. The commissioner shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) enter into a contract, including, but not limited to, a contract with another state, for facilities, services

and programs to implement the purposes of the department as established by statute; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases, emergency illnesses and health conditions and a list of reportable laboratory findings and amend such lists as the commissioner deems necessary and distribute such lists as well as any necessary forms to each licensed physician, licensed physician assistant, licensed advanced practice registered nurse and clinical laboratory in this state. The commissioner shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health, boards of health and registrars of vital statistics; and (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section 17a-688 and regulations adopted thereunder. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. The commissioner shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. The commissioner shall assist and advise local

directors of health and district directors of health in the performance of their duties, and may require the enforcement of any law, regulation or ordinance relating to public health. In the event the commissioner reasonably suspects impropriety on the part of a local director of health or district director of health, or employee of such director, in the performance of his or her duties, the commissioner shall provide notification and any evidence of such impropriety to the appropriate governing authority of the municipal health authority, established pursuant to section 19a-200, or the district department of health, established pursuant to section 19a-244, for purposes of reviewing and assessing a director's or an employee's compliance with such duties. Such governing authority shall provide a written report of its findings from the review and assessment to the commissioner not later than ninety days after such review and assessment. When requested by local directors of health or district directors of health, the commissioner shall consult with them and investigate and advise concerning any condition affecting public health within their jurisdiction. The commissioner shall investigate nuisances and conditions affecting, or that he or she has reason to suspect may affect, the security of life and health in any locality and, for that purpose, the commissioner, or any person authorized by the commissioner, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by the commissioner shall have the authority conferred by law upon constables. Whenever the commissioner determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department or health district, he or she shall forthwith take such measures, including the performance of any act required of the local health department or health district, to ensure enforcement of such statute or regulation and shall inform the local health department or health district of such measures. In September of each year the commissioner shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government,

the state, any political subdivision thereof, any other state or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may establish state-wide and regional advisory councils. For purposes of this section, "employee of such director" means an employee of, a consultant employed or retained by or an independent contractor retained by a local director of health, a district director of health, a local health department or a health district.

Sec. 25. Subsection (a) of section 19a-26 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) The Department of Public Health may establish, maintain and control state laboratories to perform examinations of supposed morbid tissues, other laboratory tests for the diagnosis and control of preventable diseases, and laboratory work in the field of sanitation, environmental and occupational testing and research studies for the protection and preservation of the public health. Such laboratory services shall be performed upon the application of licensed physicians, other laboratories, licensed dentists, licensed podiatrists, <u>licensed physician assistants,</u> licensed advanced practice registered nurses, local directors of health, public utilities or state departments or institutions, subject to regulations prescribed by the Commissioner of Public Health, and upon payment of any applicable fee as provided in this subsection. For such purposes the department may provide necessary buildings and apparatus, employ, subject to the provisions of chapter 67, administrative and scientific personnel and assistants and do all things necessary for the conduct of such laboratories. The Commissioner of Public Health may establish a schedule of fees, provided the commissioner waives the fees for local directors of health and local law enforcement agencies. If the commissioner establishes a schedule of fees, the commissioner may waive (1) the fees, in full or in part, for others if the commissioner determines that the public health requires a waiver, and (2) fees for chlamydia and gonorrhea testing for nonprofit organizations and institutions of higher education if the organization or

institution provides combination chlamydia and gonorrhea test kits. The commissioner shall also establish a fair handling fee which a client of a state laboratory may charge a person or third party payer for arranging for the services of the laboratory. Such client shall not charge an amount in excess of such handling fee.

Sec. 26. Section 19a-264 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

The local director of health shall transmit to any physician, physician assistant or advanced practice registered nurse reporting a case or suspected case of tuberculosis as provided in section 19a-262, a printed statement describing such procedure and precautions as are deemed necessary or advisable to be taken on the premises occupied by a tuberculosis patient, and such precautions shall be communicated to the family of the patient. Any physician licensed pursuant to chapter 370, physician assistant licensed pursuant to chapter 370 or advanced practice registered nurse licensed pursuant to chapter 378, who wilfully makes any false statements in the reports provided for in said section, and any person violating any of the provisions of said section, shall be fined not less than five dollars nor more than fifty dollars or imprisoned not more than six months or be both fined and imprisoned.

Sec. 27. Subsection (b) of section 19a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) A facility shall not transfer or discharge a resident from the facility except to meet the welfare of the resident which cannot be met in the facility, or unless the resident no longer needs the services of the facility due to improved health, the facility is required to transfer the resident pursuant to section 17b-359 or 17b-360, or the health or safety of individuals in the facility is endangered, or in the case of a self-pay resident, for the resident's nonpayment or arrearage of more than fifteen days of the per diem facility room rate, or the facility ceases to operate. In each case the basis for transfer or discharge shall be documented in

the resident's medical record by a physician, a physician assistant or an advanced practice registered nurse. In each case where the welfare, health or safety of the resident is concerned the documentation shall be by the resident's physician, physician assistant or **[**the resident's**]** advanced practice registered nurse. A facility that is part of a continuing care facility which guarantees life care for its residents may transfer or discharge (1) a self-pay resident who is a member of the continuing care community and who has intentionally transferred assets in a sum that will render the resident unable to pay the costs of facility care in accordance with the contract between the resident and the facility, or (2) a self-pay resident who is not a member of the continuing care community and who has intentionally transferred assets in a sum that will render the resident unable to pay the costs of a total of forty-two months of facility care from the date of initial admission to the facility.

Sec. 28. Subsection (e) of section 19a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(e) Except in an emergency or in the case of transfer to a hospital, no resident shall be transferred or discharged from a facility unless a discharge plan has been developed by the personal physician, physician assistant or advanced practice registered nurse of the resident or the medical director in conjunction with the nursing director, social worker or other health care provider. To minimize the disruptive effects of the transfer or discharge on the resident, the person responsible for developing the plan shall consider the feasibility of placement near the resident's relatives, the acceptability of the placement to the resident and the resident's guardian or conservator, if any, or the resident's legally liable relative or other responsible party, if known, and any other relevant factors that affect the resident's adjustment to the move. The plan shall contain a written evaluation of the effects of the transfer or discharge on the resident and a statement of the action taken to minimize such effects. In addition, the plan shall outline the care and kinds of services that the resident shall receive upon transfer or discharge. Not less than thirty days prior to an involuntary transfer or

discharge, a copy of the discharge plan shall be provided to the resident's personal physician, physician assistant or advanced practice registered nurse if the discharge plan was prepared by the medical director, to the resident and the resident's guardian or conservator, if any, or legally liable relative or other responsible party, if known.

Sec. 29. Subsection (a) of section 19a-550 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) As used in this section, (A) "nursing home facility" has the same meaning as provided in section 19a-521, (B) "residential care home" has the same meaning as provided in section 19a-521, and (C) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician, a physician assistant or an advanced practice registered nurse in a patient's medical record.

Sec. 30. Subsections (a) to (c), inclusive, of section 19a-571 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Subject to the provisions of subsection (c) of this section, any physician licensed under chapter 370, any physician assistant licensed under chapter 370, any advanced practice registered nurse licensed under chapter 378 or any licensed medical facility who or which withholds, removes or causes the removal of a life support system of an incapacitated patient shall not be liable for damages in any civil action

or subject to prosecution in any criminal proceeding for such withholding or removal, provided (1) the decision to withhold or remove such life support system is based on the best medical judgment of the attending physician, physician assistant or advanced practice registered nurse in accordance with the usual and customary standards of medical practice; (2) the attending physician, physician assistant or advanced practice registered nurse deems the patient to be in a terminal condition or, in consultation with a physician qualified to make a neurological diagnosis who has examined the patient, deems the patient to be permanently unconscious; and (3) the attending physician, physician assistant or advanced practice registered nurse has considered the patient's wishes concerning the withholding or withdrawal of life support systems. In the determination of the wishes of the patient, the attending physician, physician assistant or advanced practice registered nurse shall consider the wishes as expressed by a document executed in accordance with sections 19a-575 and 19a-575a, if any such document is presented to, or in the possession of, the attending physician, physician assistant or advanced practice registered nurse at the time the decision to withhold or terminate a life support system is made. If the wishes of the patient have not been expressed in a living will the attending physician, physician assistant or advanced practice registered nurse shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician, physician assistant or advanced practice registered nurse and, if available, the patient's health care representative, the patient's next of kin, the patient's legal guardian or conservator, if any, any person designated by the patient in accordance with section 1-56r and any other person to whom the patient has communicated his or her wishes, if the attending physician, physician assistant or advanced practice registered nurse has knowledge of such person. All persons acting on behalf of the patient shall act in good faith. If the attending physician, physician assistant or advanced practice registered nurse does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration **[**must**]** shall be provided.

(b) A physician qualified to make a neurological diagnosis who is consulted by the attending physician, physician assistant or advanced practice registered nurse pursuant to subdivision (2) of subsection (a) of this section shall not be liable for damages or subject to criminal prosecution for any determination made in accordance with the usual and customary standards of medical practice.

(c) In the case of an infant, as defined in 45 CFR 1340.15 (b), the physician, physician assistant, advanced practice registered nurse or licensed medical facility shall comply with the provisions of 45 CFR 1340.15 (b)(2) in addition to the provisions of subsection (a) of this section.

Sec. 31. Section 19a-580 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Within a reasonable time prior to withholding or causing the removal of any life support system pursuant to sections 19a-570, 19a-571, as amended by this act, 19a-573 and 19a-575 to 19a-580c, inclusive, the attending physician, physician assistant or advanced practice registered nurse shall make reasonable efforts to notify the individual's health care representative, next-of-kin, legal guardian, conservator or person designated in accordance with section 1-56r, if available.

Sec. 32. Subdivision (12) of section 19a-581 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(12) "Health care provider" means any physician, physician assistant, dentist, nurse, provider of services for persons with psychiatric disabilities or persons with intellectual disability or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

Sec. 33. Subdivisions (5) to (7), inclusive, of subsection (d) of section

19a-582 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(5) In cases where a health care provider or other person, including volunteer emergency medical services, fire and public safety personnel, in the course of his or her occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his or her occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician, physician assistant or advanced practice registered nurse or, if the patient or person does not have a personal physician, physician assistant or advanced practice registered nurse or if the patient's or person's physician, physician assistant or advanced practice registered nurse is unavailable, another physician, physician assistant, advanced practice registered nurse or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an HIV test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the HIV testing of a patient or other person, nor the health

facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's determination and performs that test shall have any liability as a result of his or her action carried out pursuant to this section, unless such person acted in bad faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician, a physician assistant or an advanced practice registered nurse not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known that could not otherwise be taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an HIV test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (c) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the HIV test shall be borne by the employer of the potentially exposed worker;

(6) In facilities operated by the Department of Correction if the facility physician, physician assistant or advanced practice registered nurse determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician, physician assistant or advanced practice registered nurse and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and

no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to this subdivision and subdivision (6) of this subsection until reasonable effort has been made to secure informed consent. When testing without consent takes place pursuant to this subdivision and subdivision (6) of this subsection, the counseling referrals and notification of test results described in subsection (c) of this section shall, nonetheless, be provide;

Sec. 34. Subsection (a) of section 19a-592 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Any licensed physician, physician assistant or advanced practice registered nurse may examine and provide prophylaxis or treatment for human immunodeficiency virus infection, or acquired immune deficiency syndrome for a minor, only with the consent of the parents or guardian of the minor unless the physician, physician assistant or advanced practice registered nurse determines that notification of the parents or guardian of the minor will result in prophylaxis or treatment being denied or the physician, physician assistant or advanced practice registered nurse determines the minor will not seek, pursue or continue prophylaxis or treatment if the parents or guardian are notified and the minor requests that his or her parents or guardian not be notified. The physician, physician assistant or advanced practice registered nurse shall fully document the reasons for the determination to provide prophylaxis or treatment without the consent or notification of the parents or guardian of the minor and shall include such documentation, signed by the minor, in the minor's clinical record. The fact of consultation, examination and prophylaxis or treatment of a minor under the provisions of this section shall be confidential and shall not be divulged without the minor's consent, including the sending of a bill for the services to any person other than the minor until the physician, physician assistant or advanced practice registered nurse consults with the minor regarding the sending of a bill, except (1) for purposes of any report made pursuant to section 19a-215, or (2) if the minor is twelve years of age or younger, the physician, physician assistant or advanced

practice registered nurse shall report the name, age and address of the minor to the Commissioner of Children and Families, or the commissioner's designee, who shall classify and evaluate such report pursuant to the provisions of section 17a-101g. As used in this subsection, "prophylaxis" means the use of medication, but does not include the administration of any vaccine, to prevent disease.

Sec. 35. Section 20-14m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) As used in this section, (1) "long-term antibiotic therapy" means the administration of oral, intramuscular or intravenous antibiotics, singly or in combination, for periods of time in excess of four weeks; and (2) "Lyme disease" means the clinical diagnosis by a physician, licensed in accordance with chapter 370, a physician assistant, licensed in accordance with chapter 370, or an advanced practice registered nurse, licensed in accordance with chapter 378, 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, on and after July 1, 2009, are recognized by the National Centers for Disease Control and Prevention as a cause of Lyme disease. Lyme disease includes an infection that meets the surveillance criteria set forth by the National Centers for Disease Control and Prevention, and other acute and chronic manifestations of such an infection as determined by a physician, licensed in accordance with **[**the provisions of**]** chapter 370, a physician assistant, licensed in accordance with chapter 370, or an advanced practice registered nurse, licensed in accordance with chapter 378, pursuant to a clinical diagnosis that is based on knowledge obtained through medical history and physical examination alone, or in conjunction with testing that provides supportive data for such clinical diagnosis.

(b) On and after July 1, 2009, a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse may

prescribe, administer or dispense long-term antibiotic therapy to a patient for a therapeutic purpose that eliminates such infection or controls a patient's symptoms upon making a clinical diagnosis that such patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease, provided such clinical diagnosis and treatment are documented in the patient's medical record by such licensed physician, licensed physician assistant or licensed advanced practice registered nurse. Notwithstanding the provisions of sections 20-8a and 20-13e, on and after said date, the Department of Public Health shall not initiate a disciplinary action against a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse and such physician, physician assistant or advanced practice registered nurse shall not be subject to disciplinary action by the Connecticut Medical Examining Board or the Connecticut State Board of Examiners for Nursing solely for prescribing, administering or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease, provided such clinical diagnosis and treatment has been documented in the patient's medical record by such licensed physician, licensed physician assistant or licensed advanced practice registered nurse.

(c) Nothing in this section shall prevent the Connecticut Medical Examining Board or the Connecticut State Board of Examiners for Nursing from taking disciplinary action for other reasons against a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse, pursuant to section 19a-17, or from entering into a consent order with such physician, physician assistant or advanced practice registered nurse pursuant to subsection (c) of section 4-177. Subject to the limitation set forth in subsection (b) of this section, for purposes of this section, the Connecticut Medical Examining Board may take disciplinary action against a licensed physician if there is any violation of the provisions of section 20-13c or a physician assistant if there is any violation of the provisions of section 20-12f and the Connecticut Board of Examiners for Nursing may take disciplinary action against a licensed advanced practice registered nurse in

accordance with the provisions of section 20-99.

Sec. 36. Subsection (e) of section 20-41a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(e) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 37. Subsection (c) of section 20-73b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) The continuing education requirements shall be waived for licensees applying for licensure renewal for the first time. The department may, for a licensee who has a medical disability or illness, grant a waiver of the continuing education requirements or may grant the licensee an extension of time in which to fulfill the requirements, provided the licensee submits to the Department of Public Health an application for waiver or extension of time on a form prescribed by said department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be

required by said department. The Department of Public Health may grant a waiver or extension for a period not to exceed one registration period, except that said department may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies to said department for an additional waiver or extension.

Sec. 38. Subsection (f) of section 20-74ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 39. Subsection (f) of section 20-126c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to

any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 40. Subsection (i) of section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(i) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this subsection to any licensee, provided the licensee submits to the Department of Public Health an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 41. Subsection (e) of section 20-132a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(e) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 42. Subsection (e) of section 20-162r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(e) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 43. Subsection (d) of section 20-191c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(d) A licensee applying for license renewal for the first time shall be exempt from the continuing education requirements under subsection (a) of this section. In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension. The commissioner may grant a waiver of the continuing education requirements to a licensee who is not engaged in active professional practice, in any form, during a registration period, provided the licensee submits a notarized application on a form prescribed by the commissioner prior to the end of the registration period. A licensee who is granted a waiver under the provisions of this subsection may not engage in professional practice until the licensee has met the continuing education requirements of this section.

Sec. 44. Subsection (f) of section 20-201a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of

the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 45. Subdivision (3) of subsection (e) of section 20-206bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(3) In individual cases involving medical disability or illness, the commissioner may grant a waiver of the continuing education or certification requirements or an extension of time within which to fulfill such requirements of this subsection to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the department. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 46. Subsection (f) of section 20-395d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October*

1, 2021):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 47. Subdivision (3) of subsection (b) of section 20-402 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(3) In individual cases involving medical disability or illness, the commissioner may grant a waiver of the continuing education requirements or an extension of time within which to fulfill such requirements of this subsection to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the department. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver

or extension.

Sec. 48. Subsection (f) of section 20-411a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department, prior to the expiration of the registration period, an application for waiver on a form prescribed by the department, along with a certification by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 49. Subsections (a) and (b) of section 20-631 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Except as provided in section 20-631b, one or more pharmacists licensed under this chapter who are determined competent in accordance with regulations adopted pursuant to subsection (d) of this section may enter into a written protocol-based collaborative drug therapy management agreement with one or more physicians licensed under chapter 370, physician assistants licensed under chapter 370 or advanced practice registered nurses licensed under chapter 378 to manage the drug therapy of individual patients. In order to enter into a written protocol-based collaborative drug therapy management

agreement, such physician, physician assistant or advanced practice registered nurse shall have established a provider-patient relationship with the patient who will receive collaborative drug therapy. Each patient's collaborative drug therapy management shall be governed by a written protocol specific to that patient established by the treating physician, physician assistant or advanced practice registered nurse in consultation with the pharmacist. For purposes of this subsection, a "provider-patient relationship" is a relationship based on (1) the patient making a medical complaint, (2) the patient providing a medical history, (3) the patient receiving a physical examination, and (4) a logical connection existing between the medical complaint, the medical history, the physical examination and any drug prescribed for the patient.

(b) A collaborative drug therapy management agreement may authorize a pharmacist to implement, modify or discontinue a drug therapy that has been prescribed for a patient, order associated laboratory tests and administer drugs, all in accordance with a patient-specific written protocol. In instances where drug therapy is discontinued, the pharmacist shall notify the treating physician, physician assistant or advanced practice registered nurse of such discontinuance no later than twenty-four hours from the time of such discontinuance. Each protocol developed, pursuant to the collaborative drug therapy management agreement, shall contain detailed direction concerning the actions that the pharmacist may perform for that patient. The protocol shall include, but need not be limited to, (1) the specific drug or drugs to be managed by the pharmacist, (2) the terms and conditions under which drug therapy may be implemented, modified or discontinued, (3) the conditions and events upon which the pharmacist is required to notify the physician, physician assistant or advanced practice registered nurse, and (4) the laboratory tests that may be ordered. All activities performed by the pharmacist in conjunction with the protocol shall be documented in the patient's medical record. The pharmacist shall report at least every thirty days to the physician, physician assistant or advanced practice registered nurse regarding the patient's drug therapy management. The collaborative drug therapy

management agreement and protocols shall be available for inspection by the Departments of Public Health and Consumer Protection. A copy of the protocol shall be filed in the patient's medical record.

Sec. 50. Subsections (a) and (b) of section 20-631a of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Not later than January 1, 2006, the Commissioner of Consumer Protection, in consultation with the Commission of Pharmacy, shall establish and operate a two-year pilot program to allow not more than ten pharmacists licensed under this chapter who are determined eligible in accordance with subsection (c) of this section and employed by or under contract with a licensed community pharmacy, to enter into a written protocol-based collaborative drug therapy management agreement with one or more physicians licensed under chapter 370, physician assistants licensed under chapter 370 or advanced practice registered nurses licensed under chapter 378, to manage the drug therapy of individual patients receiving drug therapy for diabetes, asthma, hypertension, hyperlipidemia, osteoporosis, congestive heart failure or smoking cessation, including patients who qualify as targeted beneficiaries under the provisions of Section 1860D-4(c)(2)(A)(ii) of the federal Social Security Act, in accordance with subsections (b) to (d), inclusive, of this section and subject to the approval of the licensed community pharmacy. Each patient's collaborative drug therapy management shall be governed by a written protocol specific to that patient established by the treating physician, physician assistant or advanced practice registered nurse in consultation with the pharmacist.

(b) A collaborative drug therapy management agreement may authorize a pharmacist to implement, modify or discontinue a drug therapy that has been prescribed for a patient, order associated laboratory tests and administer drugs, all in accordance with a patient-specific written protocol. Each protocol developed, pursuant to the collaborative drug therapy management agreement, shall contain detailed direction concerning the actions that the pharmacist may

perform for that patient. The protocol shall include, but need not be limited to, (1) the specific drug or drugs to be managed by the pharmacist, (2) the terms and conditions under which drug therapy may be implemented, modified or discontinued, (3) the conditions and events upon which the pharmacist is required to notify the physician, physician assistant or advanced practice registered nurse, and (4) the laboratory tests that may be ordered. All activities performed by the pharmacist in conjunction with the protocol shall be documented in the patient's medical record. The pharmacist shall report to the physician, physician assistant or advanced practice registered nurse through oral, written or electronic manner regarding the implementation, administration, modification or discontinuation of a drug therapy that has been prescribed for a patient not later than twenty-four hours after such implementation, administration, modification or discontinuation. The collaborative drug therapy management agreement and protocols shall be available for inspection by the Departments of Public Health and Consumer Protection. A copy of the protocol shall be filed in the patient's medical record.

Sec. 51. Section 21a-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Every contract for health club services shall provide that such contract may be cancelled within three business days after the date of receipt by the buyer of a copy of the contract, by written notice delivered by certified or registered United States mail to the seller or the seller's agent at an address which shall be specified in the contract. After receipt of such cancellation, the health club may request the return of contract forms, membership cards and any and all other documents and evidence of membership previously delivered to the buyer. Cancellation shall be without liability on the part of the buyer, except for the fair market value of services actually received and the buyer shall be entitled to a refund of the entire consideration paid for the contract, if any, less the fair market value of the services or use of facilities already actually received. Such right of cancellation shall not be affected by the terms of the contract and may not be waived or otherwise surrendered. Such

contract for health club services shall also contain a clause providing that if the person receiving the benefits of such contract relocates further than twenty-five miles from a health club facility operated by the seller or a substantially similar health club facility which would accept the seller's obligation under the contract, or dies during the membership term following the date of such contract, or if the health club ceases operation at the location where the buyer entered into the contract, the buyer or his estate shall be relieved of any further obligation for payment under the contract not then due and owing. The contract shall also provide that if the buyer becomes disabled during the membership term, the buyer shall have the option of (1) being relieved of liability for payment on that portion of the contract term for which he is disabled, or (2) extending the duration of the original contract at no cost to the buyer for a period equal to the duration of the disability. The health club shall have the right to require and verify reasonable evidence of relocation, disability or death. In the case of disability, the health club may require that a certificate signed by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse be submitted as verification and may also require in such contract that the buyer submit to a physical examination by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse agreeable to the buyer and the health club, the cost of which examination shall be borne by the health club.

Sec. 52. Subsection (b) of section 22a-616 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) Notwithstanding the provisions of section 22a-617, on and after January 1, 2003, no person shall offer for sale or distribute for promotional purposes mercury fever thermometers except by prescription written by a physician, a physician assistant or an advanced practice registered nurse. A manufacturer of mercury fever thermometers shall provide the buyer or the recipient with notice of mercury content, instructions on proper disposal and instructions that clearly describe how to carefully handle the thermometer to avoid

breakage and on proper cleanup should a breakage occur.

Sec. 53. Section 26-29a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

No fee shall be charged for any sport fishing license issued under this chapter to any person with intellectual disability, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof of intellectual disability shall consist of a certificate to that effect issued by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse.

Sec. 54. Section 26-29b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

No fee shall be charged for any hunting, sport fishing or trapping license issued under this chapter to any person with physical disability, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. For the purposes of this section, a "person with physical disability" is any person whose disability consists of the loss of one or more limbs or the permanent loss of the use of one or more limbs. A person with physical disability shall submit to the commissioner a certification, signed by a licensed physician, a licensed physician assistant or a licensed advanced practice registered nurse, of such physical disability. No fee shall be charged for any hunting or sport fishing license issued under this chapter to any person with physical disability who is not a resident of this state if such person is a resident of a state in which a person with physical disability from Connecticut will not be required to pay a fee for a hunting or sport fishing license, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35.

Sec. 55. Subsection (b) of section 31-51rr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) (1) Any employee of a political subdivision of the state who has

worked at least twelve months and one thousand two hundred fifty hours for such employer during the previous twelve-month period, or (2) on or after the effective date of regulations adopted pursuant to subsection (f) of this section, a school paraprofessional in an educational setting who has been employed for at least twelve months by such employer and for at least nine hundred fifty hours of service with such employer during the previous twelve-month period may request leave in order to serve as an organ or bone marrow donor, provided such employee may be required, prior to the inception of such leave, to provide sufficient written certification from the physician of such employee, a physician assistant or an advanced practice registered nurse of the proposed organ or bone marrow donation and the probable duration of the employee's recovery from such donation.

Sec. 56. Subdivision (1) of subsection (c) of section 31-235 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) (1) Notwithstanding the provisions of subsection (a) or (b) of this section, an unemployed individual may limit such individual's availability for work to part-time employment, provided the individual (A) provides documentation from a licensed physician, physician assistant or **[**an**]** advanced practice registered nurse that (i) the individual has a physical or mental impairment that is chronic or is expected to be long-term or permanent in nature, and (ii) the individual is unable to work full-time because of such impairment, and (B) establishes, to the satisfaction of the administrator, that such limitation does not effectively remove such individual from the labor force.

Sec. 57. Subsections (a) to (f), inclusive, of section 31-294d of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) The employer, as soon as the employer has knowledge of an injury, shall provide a competent physician, surgeon, physician assistant or advanced practice registered nurse to attend the injured

employee and, in addition, shall furnish any medical and surgical aid or hospital and nursing service, including medical rehabilitation services and prescription drugs, as the physician, surgeon, physician assistant or advanced practice registered nurse **[**surgeon**]** deems reasonable or necessary. The employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall be responsible for paying the cost of such prescription drugs directly to the provider. If the employer utilizes an approved providers list, when an employee reports a work-related injury or condition to the employer the employer shall provide the employee with such approved providers list within two business days of such reporting.

(2) If the injured employee is a local or state police officer, state marshal, judicial marshal, correction officer, emergency medical technician, paramedic, ambulance driver, firefighter, or active member of a volunteer fire company or fire department engaged in volunteer duties, who has been exposed in the line of duty to blood or bodily fluids that may carry blood-borne disease, the medical and surgical aid or hospital and nursing service provided by the employer shall include any relevant diagnostic and prophylactic procedure for and treatment of any blood-borne disease.

(b) The employee shall select the physician, surgeon, physician assistant or advanced practice registered nurse from an approved list of physicians, surgeons, physician assistants and advanced practice registered nurses prepared by the chairman of the Workers' Compensation Commission. If the employee is unable to make the selection, the employer shall do so, subject to ratification by the employee or his next of kin. If the employer has a full-time staff physician, physician assistant or advanced practice registered nurse or if a physician, physician assistant or advanced practice registered nurse is available on call, the initial treatment required immediately following the injury may be rendered by that physician, physician assistant or advanced practice registered nurse, but the employee may thereafter select his own physician, physician assistant or advanced practice registered nurse as provided by this chapter for any further treatment

without prior approval of the commissioner.

(c) The commissioner may, without hearing, at the request of the employer or the injured employee, when good reason exists, or on his own motion, authorize or direct a change of physician, surgeon, physician assistant or advanced practice registered nurse or hospital or nursing service provided pursuant to subsection (a) of this section.

(d) (1) The pecuniary liability of the employer for the medical and surgical service required by this section shall be limited to the charges that prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when the similar treatment is paid for by the injured person. Notwithstanding the provisions of chapter 368z, prior to the date the liability of the employer is established pursuant to subdivision (2) of this subsection, the liability of the employer for hospital service shall be determined exclusively by the provisions of this subdivision and shall remain the amount it actually costs the hospital to render the service, as determined by the commissioner, except in the case of state humane institutions, the liability of the employer shall be the per capita cost as determined by the Comptroller under the provisions of section 17b-223. All disputes concerning liability for hospital services in workers' compensation cases shall be filed not later than one year from the date the initial payment for services was remitted, regardless of the date such services were provided, unless any applicable law, rule or regulation establishes a shorter time frame, and shall be settled by the commissioner in accordance with this chapter.

(2) Commencing ninety days after the formulas established by the chairman of the Workers' Compensation Commission have been published pursuant to subsection (e) of this section, unless the employer and hospital or ambulatory surgical center have otherwise negotiated to determine the liability of the employer for hospital or ambulatory surgical center services required by this section, the liability of the employer for hospital or ambulatory surgical center services shall be: (A) If such services are covered by Medicare, limited to the

reimbursements listed in such formulas published pursuant to subsection (e) of this section, or (B) if such services are not covered by Medicare, determined by the chairman, in consultation with employers and their insurance carriers, self-insured employers, hospitals, ambulatory surgical centers, third-party reimbursement organizations and other entities as deemed necessary by the Workers' Compensation Commission.

(e) Not later than January 1, 2015, the chairman of the Workers' Compensation Commission shall, in consultation with employers and their insurance carriers, self-insured employers, hospitals, ambulatory surgical centers, third-party reimbursement organizations and other entities as deemed necessary by the Workers' Compensation Commission, establish and publish Medicare-based formulas, when available, to set the liability of employers for hospital and ambulatory surgical center services required by this section that are covered by Medicare. After the initial publication of such formulas, the chairman shall publish such formulas on each January first thereafter.

(f) If the employer fails to promptly provide a physician, surgeon, physician assistant or advanced practice registered nurse or any medical and surgical aid or hospital and nursing service as required by this section, the injured employee may obtain a physician, surgeon, physician assistant or advanced practice registered nurse, selected from the approved list prepared by the chairman, or such medical and surgical aid or hospital and nursing service at the expense of the employer.

Sec. 58. Section 31-294i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

For the purpose of adjudication of claims for payment of benefits under the provisions of this chapter to a uniformed member of a paid municipal fire department or a regular member of a paid municipal police department or constable who began such employment on or after July 1, 1996, any condition or impairment of health caused by a cardiac

emergency occurring to such member on or after July 1, 2009, while such member is in training for or engaged in fire duty at the site of an accident or fire, or other public safety operation within the scope of such member's employment for such member's municipal employer that results in death or temporary or permanent total or partial disability, shall be presumed to have been suffered in the line of duty and within the scope of such member's employment, unless the contrary is shown by a preponderance of the evidence, provided such member successfully passed a physical examination on entry into service conducted by a licensed physician, physician assistant or advanced practice registered nurse designated by such department which examination failed to reveal any evidence of such condition. For the purposes of this section, "cardiac emergency" means cardiac arrest or myocardial infarction, and "constable" means any municipal law enforcement officer who is authorized to make arrests and has completed Police Officer Standards and Training Council certification pursuant to section 7-294a.

Sec. 59. Subsection (a) of section 31-308 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) If any injury for which compensation is provided under the provisions of this chapter results in partial incapacity, the injured employee shall be paid a weekly compensation equal to seventy-five per cent of the difference between the wages currently earned by an employee in a position comparable to the position held by the injured employee before his injury, after such wages have been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act in accordance with section 31-310, and the amount he is able to earn after the injury, after such amount has been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act in accordance with section 31-310, except that when (1) the physician, physician assistant or **[**the**]** advanced practice registered nurse attending an injured employee certifies that the employee is unable to perform his usual work but is able to perform

other work, (2) the employee is ready and willing to perform other work in the same locality and (3) no other work is available, the employee shall be paid his full weekly compensation subject to the provisions of this section. Compensation paid under this subsection shall not be more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, and shall continue during the period of partial incapacity, but no longer than five hundred twenty weeks. If the employer procures employment for an injured employee that is suitable to his capacity, the wages offered in such employment shall be taken as the earning capacity of the injured employee during the period of the employment.

Sec. 60. Subdivision (1) of subsection (a) of section 38a-457 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(1) "Accelerated benefits" means benefits payable under a life insurance policy sold in this state: (A) During the lifetime of the insured, in a lump sum or in periodic payments, as specified in the policy, (B) upon the occurrence of a qualifying event, as defined in the policy, and certified by a physician, a physician assistant or an advanced practice registered nurse who is licensed under the laws of a state or territory of the United States, or such other foreign or domestic jurisdiction as the Insurance Commissioner may approve, and (C) which reduce the death benefits otherwise payable under the life insurance policy.

Sec. 61. Section 38a-465g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Before entering into a life settlement contract with any owner of a policy wherein the insured is terminally ill or chronically ill, a provider shall obtain:

(1) If the owner is the insured, a written statement from a licensed attending physician, physician assistant or **[**an**]** advanced practice registered nurse that the owner is of sound mind and under no

constraint or undue influence to enter into the settlement contract; and

(2) A document in which the insured consents to the release of the insured's medical records to a provider, broker or insurance producer, and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a provider, broker or life insurance producer on a form approved by the commissioner not later than thirty calendar days after the date the request was received. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation regarding the validity of the policy.

(c) Prior to or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract, that the owner has a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness or condition and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(d) If a broker or life insurance producer performs any of the activities required of the provider under this section, the provider shall be deemed to have fulfilled the requirements of this section.

(e) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(f) Not later than twenty days after an owner executes the life

settlement contract, the provider shall give written notice to the insurer that issued the policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by a copy of the medical records release required under subdivision (2) of subsection (a) of this section and a copy of the insured's application for the life settlement contract.

(g) All medical information solicited or obtained by any person licensed pursuant to this part shall be subject to applicable provisions of law relating to the confidentiality of medical information.

(h) Each life settlement contract entered into in this state shall provide that the owner may rescind the contract not later than fifteen days from the date it is executed by all parties thereto. Such rescission exercised by the owner shall be effective only if both notice of rescission is given to the provider and the owner repays all proceeds and any premiums, loans and loan interest paid by the provider within the rescission period. A failure to provide written notice of the right of rescission shall toll the period of such right until thirty days after the written notice of the right of rescission has been given. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the provider.

(i) Not later than three business days after the date the provider receives the documents from the owner to effect the transfer of the insurance policy, the provider shall pay or transfer the proceeds of the settlement into an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. Not later than three business days after receiving acknowledgment of the transfer of the insurance policy from the issuer of the policy, said trustee or escrow agent shall pay the settlement proceeds to the owner.

(j) Failure to tender the life settlement contract proceeds to the owner within the time set forth in section 38a-465f shall render the viatical

settlement contract voidable by the owner for lack of consideration until the time such consideration is tendered to, and accepted by, the owner.

(k) Any fee paid by a provider, party, i individual or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained and not as a percentage of the face value of the policy. Nothing in this section shall be construed to prohibit a broker from reducing such broker's fee below such percentage.

(l) Each broker shall disclose to the owner anything of value paid or given to such broker in connection with a life settlement contract concerning the owner.

(m) No person at any time prior to, or at the time of, the application for or issuance of a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest or surrender of the policy is to occur. This prohibition shall not apply if the owner certifies to the provider that:

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is not less than twenty-four months. The time covered under a group policy shall be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

(2) The owner submits independent evidence to the provider that one or more of the following conditions have been met within said two-year period: (A) The owner or insured is terminally ill or chronically ill; (B) the owner or insured disposes of the owner or insured's ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued; (C) the owner's spouse dies; (D) the owner divorces his

or her spouse; (E) the owner retires from full-time employment; (F) the owner has a physical or mental disability and a physician, a physician assistant or an advanced practice registered nurse determines that the disability prevents the owner from maintaining full-time employment; or (G) a final order, judgment or decree is entered by a court of competent jurisdiction on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee or liquidator to all or a substantial part of the owner's assets.

(n) Copies of the independent evidence required by subdivision (2) of subsection (m) of this section shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. Nothing in this section shall prohibit an insurer from exercising its right to contest the validity of any policy.

(o) If, at the time the provider submits a request to the insurer to effect the transfer of the policy to the provider, the provider submits a copy of independent evidence of subparagraph (A) of subdivision (2) of subsection (m) of this section, such copy shall be deemed to establish that the settlement contract satisfies the requirements of this section.

Sec. 62. Subsection (a) of section 38a-489 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1)

incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician, physician assistant or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

Sec. 63. Subsection (b) of section 38a-492e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) Benefits shall cover: (1) Initial training visits provided to an individual after the individual is initially diagnosed with diabetes that is medically necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of ten hours; (2) training and education that is medically necessary as a result of a subsequent diagnosis by a physician, a physician assistant or an advanced practice registered nurse of a significant change in the individual's symptoms or condition which requires modification of the individual's program of self-management of diabetes, totaling a maximum of four hours; and (3) training and education that is medically necessary because of the development of new techniques and treatment for diabetes totaling a maximum of four hours.

Sec. 64. Section 38a-492m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the

date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician, prescribing physician assistant, prescribing advanced practice registered nurse or prescribing optometrist indicates on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 65. Subsections (b) to (e), inclusive, of section 38a-493 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) For the purposes of this section and section 38a-494:

(1) "Hospital" means an institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of persons who have an injury, sickness or disability, or (B) medical rehabilitation services for the rehabilitation of persons who have an injury, sickness or disability. "Hospital" does not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490;

(2) "Home health care" means the continued care and treatment of a covered person who is under the care of a physician, a physician assistant or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician, physician assistant or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with

a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live;

(3) "Home health agency" means an agency or organization that meets each of the following requirements: (A) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; (B) its policies are established by a professional group associated with such agency or organization, including at least one physician, physician assistant or advanced practice registered nurse and at least one registered nurse, to govern the services provided; (C) it provides for full-time supervision of such services by a physician, a physician assistant, an advanced practice registered nurse or a registered nurse; (D) it maintains a complete medical record on each patient; and (E) it has an administrator; and

(4) "Medical social services" means services rendered, under the direction of a physician, a physician assistant or an advanced practice registered nurse, by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment, (B) appropriate action and utilization of community resources to assist in resolving such problems, and (C) participation in the development of the overall plan of treatment for such covered person.

(c) Home health care shall be provided by a home health agency.

(d) Home health care shall consist of, but shall not be limited to, the

following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, a physician assistant or an advanced practice registered nurse **[**or physician assistant**]** and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services provided to or for the benefit of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live.

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy or contract, except in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

Sec. 66. Subsections (c) to (e), inclusive, of section 38a-495 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) Each Medicare supplement policy shall provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare, provided (1) such services are provided by a certified home health aide employed by a

home health care agency licensed pursuant to sections 19a-490 to 19a-503, inclusive, and (2) the individual's physician, physician assistant or advanced practice registered nurse has certified, in writing, that such services are medically necessary. The policy shall not be required to provide benefits in excess of five hundred dollars per year for such services. No deductible or coinsurance provisions may be applicable to such benefits. If two or more Medicare supplement policies are issued to the same individual by the same insurer, such coverage for home health aide services shall be included in only one such policy. Notwithstanding the provisions of subsection (g) of this section, the provisions of this subsection shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1986.

(d) Whenever a Medicare supplement policy provides coverage for the cost of prescription drugs prescribed after the hospitalization of the insured, outpatient surgical procedures performed on the insured in any licensed hospital shall constitute "hospitalization" for purposes of such prescription drug coverage in such policy.

(e) Notwithstanding the provisions of subsection (g) of this section, each Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1988, shall provide benefits, to any woman covered under the policy, for mammographic examinations every year, or more frequently if recommended by the woman's physician, physician assistant or advanced practice registered nurse, when such examinations are not paid for by Medicare.

Sec. 67. Subdivision (1) of subsection (a) of section 38a-496 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(1) "Occupational therapy" means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a physician licensed in accordance with the

provisions of chapter 370, a physician assistant licensed in accordance with the provisions of chapter 370 or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378, who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan shall be reviewed and certified at least every two months by such physician, physician assistant or advanced practice registered nurse.

Sec. 68. Subsections (b) to (d), inclusive, of section 38a-503 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammograms to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound screening of an entire breast or breasts if: (i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; (ii) a woman is believed to be at increased risk for breast cancer due to (I) family history or prior personal history of breast cancer, (II) positive genetic testing, or (III) other indications as determined by a woman's physician, physician assistant or advanced practice registered nurse; or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is

forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

(c) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

(d) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall 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<u>, physician assistant's</u> or advanced practice registered nurse's office and you should contact your physician<u>, physician assistant</u> or advanced practice registered nurse if you have any questions or

concerns about this report.".

Sec. 69. Subsection (a) of section 38a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician, physician assistant or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

Sec. 70. Subsection (b) of section 38a-518e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) Benefits shall cover: (1) Initial training visits provided to an individual after the individual is initially diagnosed with diabetes that is medically necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of ten hours; (2) training and education that is medically necessary as a result of a subsequent diagnosis by a physician, a physician assistant or an advanced practice registered nurse of a significant change in the individual's symptoms or condition which requires modification of the individual's program of self-management

of diabetes, totaling a maximum of four hours; and (3) training and education that is medically necessary because of the development of new techniques and treatment for diabetes totaling a maximum of four hours.

Sec. 71. Section 38a-518*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician, prescribing physician assistant, prescribing advanced practice registered nurse or prescribing optometrist indicates on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 72. Subsections (b) to (e), inclusive, of section 38a-520 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) For the purposes of this section and section 38a-494:

(1) "Hospital" means an institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of persons who have an injury, sickness or disability, or (B) medical rehabilitation services for the rehabilitation of persons who have an injury, sickness or disability. "Hospital" does not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490;

(2) "Home health care" means the continued care and treatment of a covered person who is under the care of a physician, a physician assistant or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician, physician assistant or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live;

(3) "Home health agency" means an agency or organization that meets each of the following requirements: (A) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; (B) its policies are established by a professional group associated with such agency or organization, including at least one physician, physician assistant or advanced practice registered nurse and at least one registered nurse, to govern the services provided; (C) it provides for full-time supervision of such services by a physician, a physician assistant, an advanced practice registered nurse or a registered nurse; (D) it maintains a complete medical record on each patient; and (E) it has an administrator;

and

(4) "Medical social services" means services rendered, under the direction of a physician, a physician assistant or an advanced practice registered nurse, by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment, (B) appropriate action and utilization of community resources to assist in resolving such problems, and (C) participation in the development of the overall plan of treatment for such covered person.

(c) Home health care shall be provided by a home health agency.

(d) Home health care shall consist of, but shall not be limited to, the following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, a physician assistant or an advanced practice registered nurse **[**or a physician assistant**]** and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services provided to or for the benefit of a covered person diagnosed by a physician, a physician assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live.

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy, except in the case of a covered person diagnosed by a physician, a physician

assistant or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

Sec. 73. Subsections (c) to (e), inclusive, of section 38a-522 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) Each Medicare supplement policy shall provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare, provided (1) such services are provided by a certified home health aide employed by a home health care agency licensed pursuant to sections 19a-490 to 19a-503, inclusive, and (2) the individual's physician, physician assistant or advanced practice registered nurse has certified, in writing, that such services are medically necessary. The policy shall not be required to provide benefits in excess of five hundred dollars per year for such services. No deductible or coinsurance provisions may be applicable to such benefits. If two or more Medicare supplement policies are issued to the same individual by the same insurer, such coverage for home health aide services shall be included in only one such policy. Notwithstanding the provisions of subsection (g) of this section, the provisions of this subsection shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1986.

(d) Whenever a Medicare supplement policy provides coverage for the cost of prescription drugs prescribed after the hospitalization of the insured, outpatient surgical procedures performed on the insured in any licensed hospital shall constitute "hospitalization" for purposes of such prescription drug coverage in such policy.

(e) Notwithstanding the provisions of subsection (g) of this section,

each Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1988, shall provide benefits, to any woman covered under the policy, for mammographic examinations every year, or more frequently if recommended by the woman's physician, physician assistant or advanced practice registered nurse, when such examinations are not paid for by Medicare.

Sec. 74. Subdivision (1) of subsection (a) of section 38a-523 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(1) "Comprehensive rehabilitation services" shall consist of the following when provided in a comprehensive rehabilitation facility pursuant to a plan of care approved in writing by a physician licensed in accordance with the provisions of chapter 370, a physician assistant licensed in accordance with the provisions of chapter 370 or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378 and reviewed by such physician, physician assistant or advanced practice registered nurse at least every thirty days to determine that continuation of such services are medically necessary for the rehabilitation of the patient: (A) Physician services, physical and occupational therapy, nursing care, psychological and audiological services and speech therapy provided by health care professionals who are licensed by the appropriate state licensing authority to perform such services; (B) social services by a social worker holding a master's degree from an accredited school of social work; (C) respiratory therapy by a certified respiratory therapist; (D) prescription drugs and medicines which cannot be self-administered; (E) prosthetic and orthotic devices, including the testing, fitting or instruction in the use of such devices; (F) other supplies or services prescribed by a physician, a physician assistant or an advanced practice registered nurse for the rehabilitation of a patient and ordinarily furnished by a comprehensive rehabilitation facility.

Sec. 75. Section 38a-530 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) For purposes of this section:

(1) "Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association; and

(2) "Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

(b) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammograms to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound screening of an entire breast or breasts if: (i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; (ii) a woman is believed to be at increased risk for breast cancer due to (I) family history or prior personal history of breast cancer, (II) positive genetic testing, or (III) other indications as determined by a woman's physician, physician assistant or advanced practice registered nurse; or (iii) such screening is

recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

(c) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

(d) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall 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, physician assistant's or advanced practice registered nurse's office and you should contact your physician, physician assistant or

advanced practice registered nurse if you have any questions or concerns about this report.".

Sec. 76. Subdivision (1) of subsection (a) of section 38a-530f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) Except as provided in subdivision (2) of this subsection, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the following benefits and services:

(A) Domestic and interpersonal violence screening and counseling for any woman;

(B) Tobacco use intervention and cessation counseling for any woman who consumes tobacco;

(C) Well-woman visits for any woman who is younger than sixty-five years of age;

(D) Breast cancer chemoprevention counseling for any woman who is at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by such woman's physician, physician assistant or advanced practice registered nurse;

(E) Breast cancer risk assessment, genetic testing and counseling;

(F) Chlamydia infection screening for any sexually-active woman;

(G) Cervical and vaginal cancer screening for any sexually-active woman;

(H) Gonorrhea screening for any sexually-active woman;

(I) Human immunodeficiency virus screening for any sexually-active woman;

(J) Human papillomavirus screening for any woman with normal cytology results who is thirty years of age or older;

(K) Sexually transmitted infections counseling for any sexually-active woman;

(L) Anemia screening for any pregnant woman and any woman who is likely to become pregnant;

(M) Folic acid supplements for any pregnant woman and any woman who is likely to become pregnant;

(N) Hepatitis B screening for any pregnant woman;

(O) Rhesus incompatibility screening for any pregnant woman and follow-up rhesus incompatibility testing for any pregnant woman who is at increased risk for rhesus incompatibility;

(P) Syphilis screening for any pregnant woman and any woman who is at increased risk for syphilis;

(Q) Urinary tract and other infection screening for any pregnant woman;

(R) Breastfeeding support and counseling for any pregnant or breastfeeding woman;

(S) Breastfeeding supplies, including, but not limited to, a breast pump for any breastfeeding woman;

(T) Gestational diabetes screening for any woman who is twenty-four to twenty-eight weeks pregnant and any woman who is at increased risk for gestational diabetes;

(U) Osteoporosis screening for any woman who is sixty years of age or older;

(V) Such additional evidence-based items or services not described in subparagraphs (A) to (U), inclusive, of this subdivision that receive a

rating of "A" or "B" in any recommendations of the United States Preventive Services Task Force effective after January 1, 2018; and

(W) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the United States Health Resources and Services Administration, as effective on January 1, 2018, and such additional preventive care and screenings provided for in any comprehensive guidelines supported by said administration and effective after January 1, 2018.

Sec. 77. Subsection (i) of section 47-88b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(i) After the conversion of a dwelling unit in a building to condominium ownership, the declarant or unit owner, for the purpose of determining if a lessee's eviction is prohibited under subsection (b) of section 47a-23c, may ask any lessee to provide proof of the age, blindness or physical disability of such lessee or any person residing with him, or of the familial relationship existing between such lessee and any person residing with him. The lessee shall provide such proof, including, in the case of alleged physical disability, a statement of a physician, a physician assistant or an advanced practice registered nurse or, in the case of alleged blindness, a statement of a physician, an advanced practice registered nurse or an optometrist, within thirty days.

Sec. 78. Subsection (d) of section 47a-23c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(d) A landlord, to determine whether a tenant is a protected tenant, may request proof of such protected status. On such request, any tenant claiming protection shall provide proof of the protected status within thirty days. The proof shall include a statement of a physician, a physician assistant or an advanced practice registered nurse in the case

of alleged blindness or other physical disability.

Sec. 79. Subsection (c) of section 51-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(c) The Jury Administrator shall have the authority to establish and maintain a list of persons to be excluded from the summoning process, which shall consist of (1) persons who are disqualified from serving on jury duty on a permanent basis due to a disability for which a licensed physician, a physician assistant or an advanced practice registered nurse has submitted a letter stating the physician's, physician assistant's or advanced practice registered nurse's opinion that such disability permanently prevents the person from rendering satisfactory jury service, (2) persons seventy years of age or older who have requested not to be summoned, (3) elected officials enumerated in subdivision (4) of subsection (a) of this section and judges enumerated in subdivision (5) of subsection (a) of this section during their term of office, and (4) persons excused from jury service pursuant to section 51-217a who have not requested to be summoned for jury service pursuant to said section. Persons requesting to be excluded pursuant to subdivisions (1) and (2) of this subsection must provide the Jury Administrator with their names, addresses, dates of birth and federal Social Security numbers for use in matching. The request to be excluded may be rescinded at any time with written notice to the Jury Administrator.

Sec. 80. Subsection (b) of section 54-204 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) In order to be eligible for compensation services under sections 54-201 to 54-218, inclusive, the applicant shall, prior to a determination on any application made pursuant to sections 54-201 to 54-218, inclusive, submit reports if reasonably available from all physicians, surgeons, physician assistants, advanced practice registered nurses or mental health professionals who have treated or examined the victim in

relation to the injury for which compensation is claimed at the time of or subsequent to the victim's injury or death. If in the opinion of the Office of Victim Services or, on review, a victim compensation commissioner, reports on the previous medical history of the victim, examination of the injured victim and a report thereon or a report on the cause of death of the victim by an impartial medical expert would be of material aid to its just determination, said office or commissioner shall order such reports and examinations. Any information received which is confidential in accordance with any provision of the general statutes shall remain confidential while in the custody of the Office of Victim Services or a victim compensation commissioner."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	20-12c
Sec. 2	*October 1, 2021*	3-39j(5)
Sec. 3	*October 1, 2021*	3-123aa(b)
Sec. 4	*October 1, 2021*	10-183b(16)
Sec. 5	*October 1, 2021*	10a-155(a)
Sec. 6	*October 1, 2021*	10a-155a
Sec. 7	*October 1, 2021*	12-94
Sec. 8	*October 1, 2021*	12-129c(a)
Sec. 9	*October 1, 2021*	12-170aa(f)
Sec. 10	*October 1, 2021*	12-170f(a)
Sec. 11	*October 1, 2021*	12-170w(a)
Sec. 12	*October 1, 2021*	14-73(b)
Sec. 13	*October 1, 2021*	14-100a(c)(2)
Sec. 14	*October 1, 2021*	14-286(c)
Sec. 15	*October 1, 2021*	14-314c(a)
Sec. 16	*October 1, 2021*	16-262c(b)(1)
Sec. 17	*October 1, 2021*	16-262d(b)
Sec. 18	*October 1, 2021*	17a-81(a)
Sec. 19	*October 1, 2021*	17b-233
Sec. 20	*October 1, 2021*	17b-236
Sec. 21	*October 1, 2021*	17b-261p(f)
Sec. 22	*October 1, 2021*	17b-278d
Sec. 23	*October 1, 2021*	18-94
Sec. 24	*October 1, 2021*	19a-2a

Sec. 25	*October 1, 2021*	19a-26(a)
Sec. 26	*October 1, 2021*	19a-264
Sec. 27	*October 1, 2021*	19a-535(b)
Sec. 28	*October 1, 2021*	19a-535(e)
Sec. 29	*October 1, 2021*	19a-550(a)
Sec. 30	*October 1, 2021*	19a-571(a) to (c)
Sec. 31	*October 1, 2021*	19a-580
Sec. 32	*October 1, 2021*	19a-581(12)
Sec. 33	*October 1, 2021*	19a-582(d)(5) to (7)
Sec. 34	*October 1, 2021*	19a-592(a)
Sec. 35	*October 1, 2021*	20-14m
Sec. 36	*October 1, 2021*	20-41a(e)
Sec. 37	*October 1, 2021*	20-73b(c)
Sec. 38	*October 1, 2021*	20-74ff(f)
Sec. 39	*October 1, 2021*	20-126c(f)
Sec. 40	*October 1, 2021*	20-126l(i)
Sec. 41	*October 1, 2021*	20-132a(e)
Sec. 42	*October 1, 2021*	20-162r(e)
Sec. 43	*October 1, 2021*	20-191c(d)
Sec. 44	*October 1, 2021*	20-201a(f)
Sec. 45	*October 1, 2021*	20-206bb(e)(3)
Sec. 46	*October 1, 2021*	20-395d(f)
Sec. 47	*October 1, 2021*	20-402(b)(3)
Sec. 48	*October 1, 2021*	20-411a(f)
Sec. 49	*October 1, 2021*	20-631(a) and (b)
Sec. 50	*October 1, 2021*	20-631a(a) and (b)
Sec. 51	*October 1, 2021*	21a-217
Sec. 52	*October 1, 2021*	22a-616(b)
Sec. 53	*October 1, 2021*	26-29a
Sec. 54	*October 1, 2021*	26-29b
Sec. 55	*October 1, 2021*	31-51rr(b)
Sec. 56	*October 1, 2021*	31-235(c)(1)
Sec. 57	*October 1, 2021*	31-294d(a) to (f)
Sec. 58	*October 1, 2021*	31-294i
Sec. 59	*October 1, 2021*	31-308(a)
Sec. 60	*October 1, 2021*	38a-457(a)(1)
Sec. 61	*October 1, 2021*	38a-465g
Sec. 62	*October 1, 2021*	38a-489(a)
Sec. 63	*October 1, 2021*	38a-492e(b)
Sec. 64	*October 1, 2021*	38a-492m

Sec. 65	*October 1, 2021*	38a-493(b) to (e)
Sec. 66	*October 1, 2021*	38a-495(c) to (e)
Sec. 67	*October 1, 2021*	38a-496(a)(1)
Sec. 68	*October 1, 2021*	38a-503(b) to (d)
Sec. 69	*October 1, 2021*	38a-515(a)
Sec. 70	*October 1, 2021*	38a-518e(b)
Sec. 71	*October 1, 2021*	38a-518*l*
Sec. 72	*October 1, 2021*	38a-520(b) to (e)
Sec. 73	*October 1, 2021*	38a-522(c) to (e)
Sec. 74	*October 1, 2021*	38a-523(a)(1)
Sec. 75	*October 1, 2021*	38a-530
Sec. 76	*October 1, 2021*	38a-530f(a)(1)
Sec. 77	*October 1, 2021*	47-88b(i)
Sec. 78	*October 1, 2021*	47a-23c(d)
Sec. 79	*October 1, 2021*	51-217(c)
Sec. 80	*October 1, 2021*	54-204(b)