

**March 2, 2026**

**Testimony of Leslie Wolfgang, Director of Public Policy, Family Institute of Connecticut Action in opposition to SB 295, AN ACT CONCERNING STATE LAW PROTECTIONS FOR HEALTH CARE PROVIDERS AND PATIENTS RELATED TO THE PROVISION OF A LEGALLY PROTECTED HEALTH CARE ACTIVITY**



My name is Leslie Wolfgang and I am the Director of Public Policy for the Family Institute of Connecticut. I am testifying in opposition to SB 295 expanding CT's Shield Law.

**Summary of Shield Law and SB 295**

Our shield law deters out-of-state plaintiffs (and enforcers) by making them financially vulnerable in CT—*unless* the claim is essentially ordinary malpractice/contract or has no CT conduct nexus (sec. 1).

Section 2 instructs CT courts that if the dispute is about a protected category, they must apply CT substantive law, not another state's law, unless federal law requires otherwise.

Section 3 makes CT a difficult jurisdiction for discovery supporting out-of-state enforcement or investigation, especially around telehealth or cross-border care.

Section 4 adds “process friction” and AG review for subpoenas touching protected care.

Section 5 creates hurdles for out-of-state prosecutions that criminalize conduct CT deems lawful.

Section 6 cuts off a common interstate discovery tool.

Section 7 bans CT agencies from helping out-of-state investigations/proceedings.

Section 8 is meant to block extradition requests premised on “effects” theories (e.g., telehealth from CT into another state) without physical presence and flight.

Section 9 shields providers from out-of-state discipline affecting CT licensing/discipline and public profiles.

Section 10 protects employment portability for providers with out-of-state “baggage” arising from protected care.

Section 11 creates a similar shield for pharmacy licensing/discipline.

Sections 12 - 15 create a state-run address shield tied to protected care.

Sections 16-18 permits facility name in prescriptions instead of prescriber name/signature.

Section 19 is an explicit “anti-importation rule” for custody/abuse determinations grounded in another state’s policy disagreement with CT’s protected care.

In summary, SB 295 is expanding Connecticut’s already generous shield laws, most notably to protect incursions by Connecticut doctors into states via telehealth and also overrule family courts in other states who have considered “gender affirming care” in their determinations.

### **Constitutional and Interstate Comity Concerns**

There are many Constitutional and practical [critiques](#) of shield laws. We are basically eroding the cooperation and comity between the states that our Country has relied upon for over 200 years. We are eroding the federalist model not just to protect policy priorities in Connecticut, but with this bill, we are eroding goodwill to impose our policy preferences on other states.

To understand how offensive this must be to other states, consider how we would feel if Texas permitted their sales people to mail assault rifles into Connecticut and then shielded gun manufacturers from lawsuits or created procedural obstacles and vindictive countersuit causes of action.

States that have thoughtfully restricted abortion or gender affirming care, may feel rightly offended at what we are considering. Not only are we making it more difficult for people to sue, with regard to “gender affirming care”, we are also protecting a particular form of treatment that is highly controversial and has only an eroding claim to medical consensus.

### **Gender Affirming Care is not worthy of special protection**

In this unsettled environment, legislation that broadly shields cross-state provision of “gender affirming care” — including through telehealth — may prematurely foreclose important safeguards and oversight mechanisms.

Procedures such as puberty blockers, cross-sex hormones, and complex surgeries—including penile inversion vaginoplasty and free-flap vaginoplasty—are irreversible and life-altering. They should not receive special legal protections in Connecticut, particularly when a physician has been disciplined for performing similar interventions in another state. And especially with regard to minors, who are especially vulnerable.

Medical interventions under the banner of “gender affirming care” such as puberty blockers and cross-sex hormones [carry implications for fertility, bone density, cardiovascular risk, and psychological outcomes](#).

It is well known that blocking puberty can cause infertility. These are not minor or reversible interventions. Why are we interrupting natural puberty? The justification often offered is suicide prevention. But that claim [deserves scrutiny](#).

Children experiencing gender dysphoria often struggle with significant underlying mental health conditions. Telling children that they are likely to commit suicide if others do not affirm their identity is not sound medical practice. Suicide prevention must be grounded in evidence—not rhetoric.

In fact, some [long-term studies](#) have shown elevated suicide rates among adults who underwent surgical interventions compared to the general population. At minimum, the [evidence](#) does not demonstrate that these irreversible procedures eliminate suicide risk.

On February 3, the American Association of Plastic Surgeons [formally rejected](#) surgical interventions for minors with gender dysphoria. Shortly thereafter, the American Medical Association affirmed that position.

On February 20, 2026, the United Kingdom’s Department of Health and Social Care announced that it was [pausing a planned clinical trial](#) of puberty blockers in children due to concerns about the safety and wellbeing of participants. The UK’s Medicines and Healthcare products Regulatory Agency (MHRA) raised serious questions about [long-term risks](#).

[Last week](#), the New York Times published an article exposing how some medical societies have based their support of “gender affirming care” on consensus, influenced by politics, instead of medical fact finding.

Appeals to authority should not replace legislative judgment. The General Assembly has a duty to independently examine the evidence and apply common sense. Public officials serve as a safeguard when medicine drifts into ideology.

## **Consumer Protection Concerns**

Because Raised Bill No. 295 limits publication of certain out-of-state disciplinary actions (Secs. 9–11), permits prescriptions to list facility names rather than individual prescribers (Secs. 16–18), and expands grounds to quash subpoenas tied to protected activity (Sec. 3) there is concern that patients and families could have reduced transparency in evaluating provider history or seeking accountability if standards are not met. Consumer protection policy traditionally rests on access to accurate information regarding licensure, malpractice history, and responsible clinicians.

Complicating record access, obscuring individual prescriber identification, or restricting the use of out-of-state disciplinary findings may unintentionally reduce transparency in precisely the areas where clarity is most needed.

### **Telehealth and Cross-state care**

The bill expressly protects Connecticut-licensed providers who are physically present in Connecticut but treat patients located in other states (Sec. 1(a)(4)(B)). Telehealth has expanded access to care nationwide, but it also raises clinical and regulatory questions:

- Adequacy of psychological screening remotely;
- Laboratory monitoring compliance;
- Emergency coordination with local providers;
- Parental involvement when minors are involved.

These issues are not unique to gender care; they arise across telemedicine. However, when interventions may have long-term developmental consequences, oversight mechanisms become especially significant especially with regard to minors acting without parental consent or notification.

Comprehensive assessment often involves mental health evaluation, laboratory monitoring, and coordinated follow-up. When care is provided across state lines, practical challenges can arise regarding continuity of care, emergency management, and communication with local providers. While telehealth has many benefits, the regulatory framework should ensure that remote delivery does not dilute safeguards, particularly in cases involving minors or complex psychiatric comorbidities.

### **Child Welfare and Interstate Custody Findings**

Section 19 of the bill prohibits Connecticut courts from enforcing another state's removal or abuse finding based solely on a parent allowing a child to receive legally protected health care activity.

While Connecticut has authority to define abuse under its own statutes (see CGS § 46b-120), the U.S. Constitution's Full Faith and Credit Clause (Art. IV, § 1) generally requires states to respect final judicial proceedings of sister states. The Supreme Court has repeatedly emphasized that while public policy exceptions exist in limited contexts, states may not broadly refuse recognition of final judgments.

Family law matters are often fact-intensive and highly individualized. A categorical statutory prohibition on admitting certain out-of-state findings may invite constitutional litigation and complicate custody proceedings. While Connecticut is entitled to define abuse under its own law, courts should retain flexibility to consider the totality of circumstances in custody and child welfare proceedings. A categorical exclusion risks oversimplifying highly fact-specific family law disputes.

### **Tension with the UCCJEA**

We should consider serious structural concerns regarding Section 19 and its interaction with Connecticut's existing interstate custody law. Connecticut has adopted the **Uniform Child Custody Jurisdiction and Enforcement Act (UCCJEA)**, codified at CGS § 46b-115 et seq., which governs how courts must recognize and enforce child custody determinations from other states. Under § 46b-115p, a Connecticut court "*shall recognize and enforce*" a custody determination of another state if that state exercised jurisdiction in substantial conformity with the Act. This language is mandatory, not discretionary. It implements both national uniformity principles and the federal Parental Kidnapping Prevention Act, which requires states to give full faith and credit to valid sister-state custody determinations.

Section 19, however, directs Connecticut courts not to enforce or apply another state's law authorizing removal of a child when that removal is based on a parent allowing a "legally protected health care activity," and further instructs courts not to admit or consider certain out-of-state abuse findings. That categorical non-recognition language sits in direct tension with the mandatory enforcement framework of § 46b-115p. The UCCJEA was specifically designed to prevent interstate custody conflicts and forum shopping by requiring states to respect one another's jurisdictional determinations. Section 19, by contrast, creates a subject-matter carve-out from that uniform system without expressly addressing how it coexists with Connecticut's UCCJEA obligations.

The bill does not reference the UCCJEA, does not include harmonizing language, and does not clarify how courts are to reconcile these competing commands. The inclusion of the phrase "notwithstanding any provision of the general statutes" suggests an intent to override conflicting state law, but it cannot override federal requirements under the Parental Kidnapping Prevention Act. As drafted, Section 19 risks placing Connecticut courts in the position of having two irreconcilable directives: one statute requiring

enforcement of valid sister-state custody orders, and another prohibiting enforcement when the underlying basis involves protected health care activity. That tension invites constitutional challenge and interstate litigation.

I urge the Committee to reject SB 297.

Learn more about Family Institute of Connecticut Action by visiting [ctfamily.org](https://ctfamily.org) or contacting Leslie Wolfgang at [ppdirector@ctfamily.org](mailto:ppdirector@ctfamily.org).

Heritage report on Shield laws:

<https://www.heritage.org/sites/default/files/2024-12/LM366.pdf>

New York Times on medical “consensus”:

<https://www.nytimes.com/2026/02/24/opinion/medical-associations-youth-gender-care.html>

Plastic surgeon statement on surgical interventions for minors

<https://www.plasticsurgery.org/for-medical-professionals/health-policy/position-statements> and AMA

[https://www.theatlantic.com/ideas/2026/02/ama-asps-gender-surgery-minors/685961/?utm\\_source=chatgpt.com](https://www.theatlantic.com/ideas/2026/02/ama-asps-gender-surgery-minors/685961/?utm_source=chatgpt.com)

Implications for long term health: <https://pubmed.ncbi.nlm.nih.gov/28945902/>

Puberty blocker trial paused:

<https://www.theguardian.com/science/2026/feb/20/uk-clinical-trial-into-puberty-blockers-paused-after-medicines-regulator-raises-concerns>;

<https://assets.publishing.service.gov.uk/media/6998b06d047739fe61889efb/Sponsor-letter110226.pdf>

Suicide and gender affirming treatment.

[https://pmc.ncbi.nlm.nih.gov/articles/PMC10027312/?utm\\_source=chatgpt.com#abstract1](https://pmc.ncbi.nlm.nih.gov/articles/PMC10027312/?utm_source=chatgpt.com#abstract1)

Penile inversion techniques:

<https://rumergendersurgery.com/gender-reassignment-surgery/vaginoplasty-techniques/#:~:text=During%20the%20Penile%20Inversion%20procedure%2C,penis%20and%20testes%20are%20removed.>