Senate

General Assembly

File No. 604

January Session, 2025

Substitute Senate Bill No. 7

Senate, April 9, 2025

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING PROTECTIONS FOR ACCESS TO HEALTH CARE AND THE EQUITABLE DELIVERY OF HEALTH CARE SERVICES IN THE STATE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-38 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A water company, as defined in section 25-32a, shall add a measured amount of fluoride to the water supply of any water system that it owns and operates and that serves twenty thousand or more persons so as to maintain an average monthly fluoride content that is not more or less than **[**0.15 of a milligram per liter different than the United States Department of Health and Human Services' most recent recommendation for optimal fluoride levels in drinking water to prevent tooth decay**]** 0.7 of a milligram of fluoride per liter of water provided such average monthly fluoride content shall not deviate greater or less than 0.15 of a milligram per liter.

Sec. 2. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health may establish an advisory committee to advise the commissioner on matters relating to recommendations by the Centers for Disease Control and Prevention and the federal Food and Drug Administration using evidence-based data from peer-reviewed literature and studies.

(b) The advisory committee may include, but need not be limited to, the following members:

(1) The dean of a school of public health at an independent institution of higher education in the state;

(2) The dean of a school of public health at a public institution of higher education in the state;

(3) A physician specializing in primary care who (A) has not less than ten years of clinical practice experience, and (B) is a professor at a medical school in the state;

(4) An infectious disease specialist who (A) has not less than ten years of clinical practice experience, and (B) is a professor at an institution of higher education in the state;

(5) A pediatrician who (A) has not less than ten years of clinical practice experience and expertise in children's health and vaccinations, and (B) is a professor at an institution of higher education in the state; and

(6) Any other individuals determined to be a beneficial member of the advisory committee by the Commissioner of Public Health.

(c) The advisory committee shall serve in a nonbinding advisory capacity, providing guidance solely at the discretion of the Commissioner of Public Health.

Sec. 3. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

(1) "Emergency medical condition" has the same meaning as provided in section 4 of this act;

(2) "Emergency medical services" has the same meaning as provided in section 4 of this act;

(3) "Gender-affirming health care services" has the same meaning as provided in section 52-571n of the general statutes;

(4) "Health care entity" means an entity that supervises, controls, grants privileges to, directs the practice of or, directly or indirectly, restricts the practice of a health care provider;

(5) "Health care provider" means a person who (A) provides health care services, (B) is licensed, certified or registered pursuant to title 20 of the general statutes, and (C) is employed by or acting on behalf of a health care entity;

(6) "Medically accurate and appropriate information and counseling" means information and counseling that is (A) supported by the weight of current scientific evidence, (B) derived from research using accepted scientific methods, (C) consistent with generally recognized scientific theory, (D) published in peer-reviewed journals, as appropriate, and (E) recognized as accurate, complete, objective and in accordance with the accepted standard of care by professional organizations and agencies with expertise in the relevant field;

(7) "Medical hazard" has the same meaning as provided in section 4 of this act; and

(8) "Reproductive health care services" has the same meaning as provided in section 52-571n of the general statutes.

(b) (1) No health care entity shall limit the ability of a health care provider who is acting in good faith, within the health care provider's scope of practice, education, training and experience, including the health care provider's specialty area of practice and board certification, and within the accepted standard of care, from providing the following with regard to reproductive health care services and gender-affirming health care services:

(A) Comprehensive, medically accurate and appropriate information and counseling that (i) conforms to the accepted standard of care provided to an individual patient, and (ii) concerns such patient's health status, including, but not limited to, diagnosis, prognosis, recommended treatment, treatment alternatives and potential risks to the patient's health or life; or

(B) Comprehensive, medically accurate and appropriate information and counseling about available and relevant services and resources in the community and methods to access such services and resources to obtain health care of the patient's choosing.

(2) Nothing in subdivision (1) of this subsection shall be construed to prohibit a health care entity that employs a health care provider from performing relevant peer review of the health care provider or requiring such health care provider to:

(A) Comply with preferred provider network or utilization review requirements of any program or entity authorized by state or federal law to provide insurance coverage for health care services to an enrollee; and

(B) Meet established health care quality and patient safety guidelines or rules.

(3) No health care entity shall discharge or discipline a health care provider solely for providing information or counseling as described in subdivision (1) of this subsection.

(c) (1) If a health care provider is acting in good faith, within the scope of the health care provider's practice, education, training and experience and within the accepted standard of care, a hospital with an emergency department shall not prohibit the health care provider from providing any emergency medical services, including reproductive health care services, (A) if the failure to provide such services would violate the accepted standard of care, or (B) if the patient is suffering from an emergency medical condition.

(2) Nothing in subdivision (1) of this subsection shall be construed to prohibit a health care entity from limiting a health care provider's practice for purposes of:

(A) Complying with preferred provider network or utilization review requirements of any program or entity authorized by state or federal law to provide insurance coverage for health care services to an enrollee; or

(B) Ensuring quality of care and patient safety, including, but not limited to, when quality of care or patient safety issues are identified pursuant to peer review.

(3) A health care entity shall not discharge or discipline a health care provider for providing any emergency medical services, including, but not limited to, reproductive health care services, (A) if the failure to provide such services would violate the accepted standard of care, or (B) if the patient is suffering from an emergency medical condition.

(4) A health care entity shall not discharge or discipline a health care provider acting within the scope of such provider's practice, education, training and experience and within the accepted standard of care who refuses to transfer a patient when the health care provider determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the patient.

Sec. 4. (NEW) (*Effective July 1, 2025*) As used in this section and sections 5 to 12, inclusive, of this act:

(1) "Emergency medical services" means (A) medical screening, examination and evaluation by a physician or any other licensed health care provider acting independently or, as required by applicable law, under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if so, the care, treatment and surgery that is (i) necessary to relieve or eliminate the emergency medical condition, and (ii) within the scope of the facility's license where the physician or provider is practicing, provided such care, treatment or

surgery is within the scope of practice of such physician or provider, and (B) if it is determined that the emergency medical condition that exists is a pregnancy complication, all reproductive health care services related to the pregnancy complication, including, but not limited to, miscarriage management and the treatment of an ectopic pregnancy, that are (i) necessary to relieve or eliminate the emergency medical condition, and (ii) within the scope of the facility's license where the physician or health care provider is providing such services, provided such services are within the scope of practice of such physician or provider.

(2) "Emergency medical condition" means a medical condition manifesting itself by acute or severe symptoms, including, but not limited to, severe pain, where the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placement of the patient's life or health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(3) "Active labor" means a labor at a time at which either of the following is true:

(A) There is inadequate time to safely transfer the patient to another hospital prior to delivery; or

(B) A transfer may pose a threat to the health and safety of the patient or the fetus.

(4) "Hospital" has the same meaning as provided in section 19a-490 of the general statutes.

(5) "Medical hazard" means a material deterioration in, or jeopardy to, a patient's medical condition or expected chances for recovery.

(6) "Qualified personnel" means a physician or other licensed health care provider acting within the scope of such person's licensure who has

the necessary licensure, training, education and experience to provide the emergency medical services necessary to stabilize a patient.

(7) "Consultation" means the rendering of an opinion or advice, prescribing treatment or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication, when determined to be medically necessary, jointly by the (A) treating physician or other qualified personnel acting within the scope of such personnel's licensure either independently or, when required by law, under the supervision of a physician, and (B) consulting physician, including, but not limited to, a review of the patient's medical record and examination and treatment of the patient in person, by telephone or through telehealth by a consulting physician or other qualified personnel acting within the scope of such personnel's licensure either independently or, when required by law, under the supervision of a consulting physician, which physician or qualified personnel is qualified to give an opinion or render the necessary treatment to stabilize the patient.

(8) "Stabilized" means the patient's medical condition is such that, within reasonable medical probability in the opinion of the treating physician or any other qualified personnel acting within the scope of such personnel's licensure either independently or, when required by law, under the supervision of a treating physician, no medical hazard is likely to result from, or occur during, the transfer or discharge of the patient as provided in section 6 or 7 of this act or any other relevant provision of the general statutes.

Sec. 5. (NEW) (*Effective July 1, 2025*) (a) Each hospital licensed pursuant to chapter 368v of the general statutes that maintains and operates (1) an emergency department to provide emergency medical services to the public, or (2) a freestanding emergency department, as defined in section 19a-493d of the general statutes, shall provide emergency medical services to any person requesting such services, or for whom such services are requested by an individual with authority to act on behalf of the person, who has a medical condition that places

the person in danger of loss of life or serious injury or illness when the hospital has appropriate facilities and qualified personnel available to provide such services.

(b) No hospital or hospital employee and no physician or other licensed health care provider affiliated with a hospital shall be liable under this section in any action arising out of a refusal of the hospital, hospital employee, physician or other licensed health care provider to render emergency medical services to a person if the refusal is based on the hospital's, hospital employee's, physician's or provider's determination, while exercising reasonable care, that (1) such person is not experiencing an emergency medical condition, or (2) the hospital does not have the appropriate facilities or qualified personnel available to render such services to such person.

(c) A hospital shall render emergency medical services to a person without first questioning such person or any other individual regarding such person's ability to pay for such services. A hospital may follow reasonable registration processes for persons for whom an examination is required under this section, including, but not limited to, inquiring as to whether the person has health insurance and, if so, details regarding such health insurance, provided such inquiry does not delay an evaluation of such person or the provision of emergency medical services to such person. Such reasonable registration processes may not unduly discourage persons from remaining at the hospital for further evaluation.

Sec. 6. (NEW) (*Effective July 1, 2025*) (a) A hospital shall not transfer any person needing emergency medical services to another hospital for any nonmedical reason, including, but not limited to, the person's inability to pay for any emergency medical services, unless each of the following conditions are met:

(1) A physician has examined and evaluated the person prior to transfer, including, if necessary, by engaging in a consultation. A request for consultation shall be made by the treating physician or by other qualified personnel acting within the scope of such personnel's

licensure either independently or, when required by law, under the supervision of a treating physician, provided the request by such qualified personnel is made with the contemporaneous approval of the treating physician.

(2) The person has been provided with emergency medical services, including, but not limited to, an abortion, if an abortion was medically necessary to stabilize the patient, and it can be determined by the hospital, within reasonable medical probability, that such person's emergency medical condition has been stabilized and the transfer or delay caused by the transfer will not create a medical hazard to such person.

(3) A physician at the transferring hospital has notified the receiving hospital and obtained consent to the transfer of the person from a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the receiving hospital's admissions criteria relating to appropriate bed, personnel and equipment necessary to treat the person.

(4) The transferring hospital has provided for appropriate personnel and equipment that a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to affect the transfer.

(5) All of the person's pertinent medical records and copies of all of the appropriate diagnostic test results that are reasonably available have been compiled for transfer with the person. Transfer of medical records may be accomplished by a transfer of physical records or by confirming that the receiving hospital has access to the patient's electronic medical records from the transferring hospital.

(6) The records transferred with the person shall include a transfer summary signed by the transferring physician that contains relevant transfer information available to the transferring hospital at the time of transfer. The form of the transfer summary shall, at a minimum, contain (A) the person's name, address, sex, race, age, insurance status, presenting symptoms and medical condition, (B) the name and business

address of the transferring physician or emergency department personnel authorizing the transfer, (C) the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient, (D) the time and date of the transfer, (E) the reason for the transfer, (F) the time and date the person was first presented at the transferring hospital, and (G) the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent. Neither the transferring physician nor the transferring hospital shall be required to duplicate, in the transfer summary, information contained in medical records transferred with the person.

(7) The hospital shall ask the patient if the patient has a preferred contact person to be notified about the transfer and, prior to the transfer, the hospital shall make a reasonable attempt to contact such person and alert them about the proposed transfer. If the patient is not able to respond, the hospital shall make a reasonable effort to ascertain the identity of the preferred contact person or the next of kin and alert such person about the transfer. The hospital shall document in the patient's medical record any attempt to contact a preferred contact person or next of kin.

(b) Nothing in this section shall be construed to prohibit the transfer or discharge of a patient when the patient or the patient's authorized representative, including a parent or guardian of the patient, requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

(c) The Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 7. (NEW) (*Effective July 1, 2025*) (a) A receiving hospital shall accept the transfer of a person from a transferring hospital to the extent required pursuant to section 6 of this act or any contract obligation the receiving hospital has to care for the person.

(b) The receiving hospital shall provide personnel and equipment reasonably required by the applicable standard of practice and the regulations adopted pursuant to section 6 of this act to care for the transferred patient.

(c) Any hospital that has suffered a financial loss as a direct result of a hospital's improper transfer of a person or refusal to accept a person for whom the hospital has a legal obligation to provide care may, in a civil action against the participating hospital, obtain damages for such financial loss and such equitable relief as is appropriate.

(d) Nothing in this section shall be construed to require a hospital to receive a person from a transferring hospital and make arrangements for the care of a person for whom the hospital does not have a legal obligation to provide care.

Sec. 8. (NEW) (*Effective July 1, 2025*) (a) The Commissioner of Public Health shall require as a condition of licensure of a hospital, pursuant to section 19a-491 of the general statutes, that each hospital adopt, in collaboration with the medical staff of the hospital, policies and transfer protocols consistent with sections 3 to 12, inclusive, of this act and the regulations adopted pursuant to section 6 of this act.

(b) The commissioner shall require as a condition of licensure of a hospital, pursuant to section 19a-491 of the general statutes, that each hospital communicate, both orally and in writing, to each person who presents to the hospital's emergency department, or such person's authorized representative, if any such representative is present and the person is unable to understand verbal or written communication, of the reasons for the transfer or refusal to provide emergency medical services and of the person's right to receive such services to stabilize an emergency medical condition prior to transfer to another hospital or health care facility or discharge without regard to ability to pay. Nothing in this subsection shall be construed to require notification of the reasons for the transfer in advance of the transfer when (1) a person is unaccompanied, (2) the hospital has made a reasonable effort to locate an authorized representative of the person, and (3) due to the person's

physical or mental condition, notification is not possible. Each hospital shall prominently post a sign in its emergency department informing the public of their rights under sections 3 to 12, inclusive, of this act. Both the written communication and sign required under this subsection shall include the contact information for the Department of Public Health and identify the department as the state agency to contact if a person wishes to complain about the hospital's conduct.

(c) Not later than thirty days after the adoption of regulations pursuant to section 6 of this act, each hospital shall submit its policies and protocols adopted pursuant to subsection (a) of this section to the Department of Public Health. Each hospital shall submit any revisions to such policies or protocols to the department not later than thirty days prior to the effective date of such revisions.

Sec. 9. (NEW) (*Effective July 1, 2025*) (a) Each hospital shall maintain records of each transfer of a person made or received, including the transfer summary described in subdivision (6) of subsection (a) of section 6 of this act, for a period of not less than three years following the date of the transfer.

(b) Each hospital making or receiving transfers of persons shall file with the Department of Public Health annual reports, in a form and manner prescribed by the Commissioner of Public Health, that shall describe the aggregate number of transfers made and received, the insurance status of each person transferred and the reasons for such transfers.

(c) Each receiving hospital, physician and licensed emergency room health care personnel at the receiving hospital, and each licensed emergency medical services personnel, as defined in section 19a-175 of the general statutes, effectuating the transfer of a person who knows of an apparent violation of any provision of sections 4 to 11, inclusive, of this act or the regulations adopted pursuant to section 6 of this act, shall, and each transferring hospital and each physician and other provider involved in the transfer at such hospital may, report such violation to the Department of Public Health, in a form and manner prescribed by

the Commissioner of Public Health, not later than fourteen days after the occurrence of such violation. When two or more persons required to report a violation have joint knowledge of an apparent violation, a single report may be made by a member of the hospital personnel selected by mutual agreement in accordance with hospital protocols. Any person required to report a violation who disagrees with a proposed joint report shall report individually.

(d) No hospital, state agency or person shall retaliate against, penalize, institute a civil action against or recover monetary relief from, or otherwise cause any injury to, any physician, other hospital personnel or emergency medical services personnel for reporting in good faith an apparent violation of any provision of sections 4 to 11, inclusive, of this act or the regulations adopted pursuant to section 6 of this act to the Department of Public Health, the hospital, a member of the hospital's medical staff or any other interested party or government agency.

Sec. 10. (NEW) (*Effective July 1, 2025*) (a) Except as otherwise provided in sections 4 to 11, inclusive, of this act, the Commissioner of Public Health shall investigate each alleged violation of said sections and the regulations adopted pursuant to section 6 of this act unless the commissioner concludes that the allegation does not include facts requiring further investigation or is otherwise unmeritorious.

(b) The Commissioner of Public Health may take any action authorized by sections 19a-494 and 19a-494a of the general statutes against a hospital or authorized by section 19a-17 of the general statutes against a licensed health care provider for a violation of any provision of sections 4 to 11, inclusive, of this act.

Sec. 11. (NEW) (*Effective July 1, 2025*) (a) A hospital shall not base the provision of emergency medical services to a person, in whole or in part, upon, or discriminate against a person based upon, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, sex, race, color, religion, disability, genetic information, marital status, sexual orientation, gender identity or expression, primary language or

immigration status, except to the extent that a circumstance such as age, sex, pregnancy, medical condition related to childbirth, preexisting medical condition or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. Each hospital shall adopt a policy to implement the provisions of this section.

(b) Unless otherwise permitted by contract, each hospital shall prohibit each physician who serves on an on-call basis in the hospital's emergency department from refusing to respond to a call on the basis of the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, sex, race, color, religion, disability, current medical condition, genetic information, marital status, sexual orientation, primary language or immigration status, except to the extent that a circumstance such as age, sex, preexisting medical condition or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. If a contract that was in existence on or before July 1, 2025, between a physician and hospital for the provision of emergency department coverage prevents a hospital from imposing the prohibition required under this subsection, the contract shall be revised to include such prohibition as soon as it is legally permissible to make such a revision. Nothing in this section shall be construed to require any physician to serve on an on-call basis for a hospital.

Sec. 12. (NEW) (*Effective July 1, 2025*) (a) Any individual harmed by a violation of any provision of sections 3 to 11, inclusive, of this act may bring, not later than one hundred eighty days after the occurrence of such violation, a civil action against a hospital or other health care entity for such violation.

(b) Any hospital or other health care entity found to have violated any provision of sections 3 to 11, inclusive, of this act shall be liable for compensatory damages, with costs and such reasonable attorney's fees as may be allowed by the court. In the case of a health care provider who has been subjected to retaliation or other disciplinary action in violation

of any provision of sections 3 to 11, inclusive, of this act, the hospital or other health care entity shall also be liable for the full amount of gross loss of wages in addition to any compensatory damages for which the hospital or health care entity is liable under this subsection.

(c) The court may also provide injunctive relief to prevent further violations of any provision of sections 3 to 11, inclusive, of this act.

(d) If the court determines that an action for damages was brought under this section without substantial justification, the court may award costs and reasonable attorney's fees to the hospital or other health care entity.

(e) Nothing in this section shall preclude any other causes of action authorized by law or prevent the state or any professional licensing board from taking any action authorized by the general statutes against the hospital, health care entity or an individual health care provider.

Sec. 13. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

(1) "Collateral costs" means any out-of-pocket costs, other than the cost of the procedure itself, necessary to receive reproductive health care services or gender-affirming health care services in the state, including, but not limited to, costs for travel, lodging and meals;

(2) "Gender-affirming health care services" has the same meaning as provided in section 52-571n of the general statutes;

(3) "Health care provider" means any person licensed under the provisions of federal or state law to provide health care services;

(4) "Nonprofit organization" means an organization that is exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(5) "Patient-identifiable data" means any information that identifies, or may reasonably be used as a basis to identify, an individual patient;

(6) "Qualified person" means a person who is a resident of a state that has enacted laws that limit such person's access to reproductive health care services or gender-affirming health care services; and

(7) "Reproductive health care services" means all medical, surgical, counseling or referral services relating to the human reproductive system, including, but not limited to, services relating to fertility, pregnancy, contraception and abortion.

(b) There is established an account to be known as the "safe harbor account", which shall be a separate, nonlapsing account of the State Treasurer. The account shall contain any funds received from any private contributions, gifts, grants, donations, bequests or devises to the account. Moneys in the account shall be expended by the board of trustees, established pursuant to subsection (c) of this section, for the purposes of providing grants to (1) health care providers who provide reproductive health care services or gender-affirming health care services, (2) nonprofit organizations whose mission includes providing funding for reproductive health care services or the collateral costs incurred by qualified persons to receive such services in the state, or (3) nonprofit organizations that serve LGBTQ+ youth or families in the state for the purpose of reimbursing or paying for collateral costs incurred by qualified persons to receive reproductive health care services or gender-affirming health care services.

(c) The safe harbor account shall be administered by a board of trustees consisting of the following members:

(1) The Treasurer, or the Treasurer's designee, who shall serve as chairperson of the board of trustees;

(2) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

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

(4) The Commissioner of Public Health, or the commissioner's

designee; and

(5) Five members appointed by the Treasurer, (A) one of whom shall be a provider of reproductive health care services in the state, (B) one of whom shall have experience working with members of the LGBTQ+ community, and (C) one of whom shall have experience working with providers of reproductive health care services. When making such appointments, the Treasurer shall use the Treasurer's best efforts to ensure that the board of trustees reflects the racial, gender and geographic diversity of the state.

(d) Not later than September 1, 2025, the board of trustees shall adopt policies and procedures concerning the awarding of grants pursuant to the provisions of this section. Such policies and procedures shall include, but need not be limited to, (1) grant application procedures, (2) eligibility criteria for applicants, (3) eligibility criteria for collateral costs, (4) consideration of need, including, but not limited to, financial need, of the applicant, and (5) procedures to coordinate with any national network created to perform similar functions to those of the safe harbor account, including, but not limited to, procedures for the acceptance of funding transferred to the safe harbor account for a particular use. Such policies and procedures shall not require the collection or retention of patient-identifiable data in order to receive a grant. Such policies and procedures may be updated as deemed necessary by the board of trustees. In the event that the board of trustees determines that the policies and procedures adopted pursuant to the provisions of this subsection are inadequate with respect to (A) determining the eligibility of a certain health care provider or nonprofit organization for a grant, or (B) whether a certain health care service received by a qualified person or collateral cost incurred by a qualified person is eligible to be reimbursed or paid by a health care provider or nonprofit organization using grant moneys received pursuant to this section, the board of trustees may make a fact-based determination as to such eligibility.

Sec. 14. (NEW) (*Effective from passage*) It is hereby declared that opioid use disorder constitutes a public health crisis in this state and will

continue to constitute a public health crisis until each goal reported by the Connecticut Alcohol and Drug Policy Council pursuant to subsection (f) of section 17a-667a of the general statutes, as amended by this act, is attained.

Sec. 15. Section 17a-667a of the general statutes is amended by adding subsection (f) as follows (*Effective from passage*):

(NEW) (f) The Connecticut Alcohol and Drug Policy Council shall convene a working group to establish one or more goals for the state to achieve in its efforts to combat the prevalence of opioid use disorder in the state. Not later than January 1, 2026, the council shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding each goal established by the working group.

Sec. 16. (*Effective from passage*) (a) As used in this section:

(1) "Priority school district" has the same meaning as described in section 10-266p of the general statutes; and

(2) "Geofence" means any technology that uses global positioning coordinates, cell tower connectivity, cellular data, radio frequency identification, wireless fidelity technology data or any other form of location detection, or any combination of such coordinates, connectivity, data, identification or other form of location detection, to establish a virtual boundary.

(b) Not later than January 1, 2026, the Department of Education, in consultation with the Department of Children and Families, shall establish a mental and behavioral health awareness and treatment pilot program in priority school districts. The program shall enable not less than one hundred thousand students in such districts to utilize an electronic mental and behavioral health awareness and treatment tool through an Internet web site, online service or mobile application, which tool shall be selected by the Commissioner of Education and provide

each of the following:

(1) Mental and behavioral health education resources to promote awareness and understanding of mental and behavioral health issues;

(2) Peer-to-peer support services, including, but not limited to, a moderated online peer chat room, where comments submitted by students for posting in the chat room are prescreened and filtered through by a moderator prior to posting, to encourage social connection and mutual support among students; and

(3) Private online sessions with mental or behavioral health care providers licensed in the state who (A) have demonstrated experience delivering mental or behavioral health care services to school districts serving both rural and urban student populations, and (B) shall be selected or approved by the Commissioner of Education, provided such sessions comply with the provisions of section 19a-906 of the general statutes concerning telehealth and the provisions of section 19a-14c of the general statutes concerning the provision of outpatient mental health treatment to minors.

(c) (1) During its first year of operation, the pilot program shall have the following objectives: (A) To build partnerships between priority school districts and community organizations providing mental and behavioral health care services; and (B) to launch a digital marketing campaign using tools, including, but not limited to, a geofence, to raise awareness and engagement among students concerning mental and behavioral health issues affecting students.

(2) Not later than January 1, 2026, the Commissioner of Education shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the program's success in achieving such objectives to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education.

(d) (1) During its second year of operation, the pilot program shall have the following objectives: (A) To refer students to mental and

behavioral health care providers, as needed; and (B) to enhance students' engagement with mental and behavioral health tools, including, but not limited to, coping strategies and clinician support.

(2) Not later than January 1, 2027, the Commissioner of Education shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the program's success in achieving such objectives to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education.

Sec. 17. (*Effective from passage*) The sum of three million six hundred thousand dollars is appropriated to the Department of Education from the General Fund, for the fiscal year ending June 30, 2026, for the administration of the mental and behavioral health awareness and treatment pilot program established pursuant to section 16 of this act.

Sec. 18. (NEW) (*Effective from passage*) There is established an account to be known as the "public health urgent communication account", which shall be a separate, nonlapsing account. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Department of Public Health for the purposes of providing timely, effective communication to members of the general public, health care providers and other relevant stakeholders during a public health emergency, as described in section 19a-131a of the general statutes.

Sec. 19. (*Effective from passage*) The sum of five million dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2026, for deposit into the "public health urgent communication account" established pursuant to section 18 of this act.

Sec. 20. (NEW) (*Effective from passage*) There is established an account to be known as the "emergency public health financial safeguard account", which shall be a separate, nonlapsing account. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Department of Public

Health for the purposes of addressing unexpected shortfalls in public health funding and ensuring the Department of Public Health's ability to respond to the health care needs of state residents and provide a continuity of essential public health services.

Sec. 21. (*Effective from passage*) The sum of thirty million dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2026, for deposit into the "emergency public health financial safeguard account" established pursuant to section 20 of this act.

Sec. 22. (NEW) (*Effective October 1, 2025*) As used in this section and sections 23 to 25, inclusive, of this act:

(1) "Commissioner" means the Commissioner of Public Health;

(2) "Department" means the Department of Public Health;

(3) "Health care administrator" means a person employed by a hospital who is a:

(A) Nonclinical hospital manager with direct supervisory authority over clinical health care providers who is responsible for one or more of the following activities:

(i) Hiring, scheduling, evaluating and providing direct supervision of clinical health care providers;

(ii) Monitoring hospital activities for compliance with state or federal regulatory requirements; or

(iii) Developing fiscal reports for clinical units of the hospital or the hospital as a whole; or

(B) Nonclinical hospital director, officer or executive who has direct or indirect supervisory authority over only nonclinical hospital managers described in subparagraph (A) of this subdivision, for one or more of the following activities:

(i) Hiring and supervising such nonclinical hospital managers;

(ii) Providing oversight of operations for the hospital or any of its departments;

(iii) Developing policies and procedures establishing the standards of patient care;

(iv) Providing oversight of budgetary and financial decisions related to operations and the delivery of patient care for the hospital or any of its departments; and

(v) Ensuring that hospital policies comply with state and federal regulatory requirements; and

(4) "Hospital" means an institution licensed as a hospital pursuant to chapter 368v of the general statutes.

Sec. 23. (NEW) (*Effective October 1, 2025*) (a) No person shall practice as a health care administrator unless such person is licensed pursuant to section 24 of this act.

(b) No person may use the title "health care administrator" or make use of any title, words, letters or abbreviations indicating or implying that such person is licensed to practice as a health care administrator pursuant to section 24 of this act.

Sec. 24. (NEW) (*Effective October 1, 2025*) (a) Except as provided in subsection (b) of this section, the commissioner shall grant a license to practice as a health care administrator to an applicant who presents evidence satisfactory to the commissioner that such applicant has: (1) A baccalaureate or graduate degree in health care administration, public health or a related field from a regionally accredited institution of higher education, or from an institution of higher education outside of the United States that is legally chartered to grant postsecondary degrees in the country in which such institution is located; (2) passed an examination prescribed by the department designed to test the applicant's knowledge of health care laws, patient safety protocols and

health-related ethical guidelines; and (3) submitted a completed application in a form and manner prescribed by the department. The fee for an initial license under this section shall be two hundred dollars.

(b) The department may grant licensure without examination, subject to payment of fees with respect to the initial application, to any applicant who is currently licensed or certified as a health care administrator in another state, territory or commonwealth of the United States, provided such state, territory or commonwealth maintains licensure or certification standards that, in the opinion of the department, are equivalent to or higher than the standards of this state. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(c) A license issued to a health care administrator under this section may be renewed annually in accordance with the provisions of section 19a-88 of the general statutes, as amended by this act. The fee for such renewal shall be one hundred five dollars. Each licensed health care administrator applying for license renewal shall furnish evidence satisfactory to the commissioner of having participated in continuing education programs prescribed by the department. The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to (1) define basic requirements for continuing education programs, (2) delineate qualifying programs, (3) establish a system of control and reporting, and (4) provide for waiver of the continuing education requirement for good cause.

Sec. 25. (NEW) (*Effective October 1, 2025*) (a) The department shall have jurisdiction to hear all charges of unacceptable conduct brought against a person licensed as a health care administrator. The commissioner shall provide written notice of such hearing to such person not later than thirty days prior to such hearing. After holding such hearing, the department may take any of the actions set forth in section 19a-17 of the general statutes, if it finds that any grounds for action by the department enumerated in subsection (b) of this section

exist. Any person aggrieved by the finding of the department may appeal such finding in accordance with the provisions of section 4-183 of the general statutes, and such appeal shall have precedence over nonprivileged cases in respect to order of trial.

(b) The department may take action under section 19a-17 of the general statutes for any of the following reasons: (1) A fiscal or operational decision that results in injury to a patient or creates an unreasonable risk that a patient may be harmed; (2) a violation by a licensed health care provider of a state or federal statute or administrative rule regulating a profession when the health care administrator was responsible for the oversight of the licensed health care provider; (3) aiding or abetting a licensed health care provider to practice the provider's health care profession after a patient complaint or adverse event has been reported to the hospital employing the licensed health care administrator, the department or the appropriate disciplining authority, while the complaint or adverse event is being investigated, and if harm, disability or death of a patient occurred after the complaint or report of the adverse event; (4) failure to adequately supervise licensed clinical staff and nonclinical staff to the extent that a patient's health or safety is at risk; (5) any administrative, operational or fiscal decision that impedes a clinical licensed health care provider from adhering to standards of practice or leads to patient harm, disability or death; or (6) a fiscal or operational decision resulting in the inability of licensed clinical health care providers to practice with reasonable skill and safety, regardless of the occurrence of patient harm, disability or death. The commissioner may order a license holder to submit to a reasonable physical or mental examination if such license holder's physical or mental capacity to practice safely is being investigated. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes.

Sec. 26. Subdivision (1) of subsection (e) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(e) (1) Each person holding a license or certificate issued under section 24 of this act, section 19a-514, 20-65k, 20-74s, 20-185k, 20-185*l*, 20-195cc or 20-206*ll* and chapters 370 to 373, inclusive, 375, 378 to 381a, inclusive, 383 to 383c, inclusive, 383g, 384, 384a, 384b, 385, 393a, 395, 399 or 400a and section 20-206n or 20-206o shall, annually, or, in the case of a person holding a license as a marital and family therapist associate under section 20-195c on or before twenty-four months after the date of initial licensure, during the month of such person's birth, apply for renewal of such license or certificate to the Department of Public Health, giving such person's name in full, such person's residence and business address and such other information as the department requests.

Sec. 27. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

(1) "Advanced practice registered nurse" means an individual licensed as an advanced practice registered nurse pursuant to chapter 378 of the general statutes;

(2) "Physician" means an individual licensed as a physician pursuant to chapter 370 of the general statutes;

(3) "Physician assistant" means an individual licensed as a physician assistant pursuant to chapter 370 of the general statutes; and

(4) "Sudden unexpected death in epilepsy" means the death of a person with epilepsy that is not caused by injury, drowning or other known causes unrelated to epilepsy.

(b) On and after October 1, 2025, each physician, advanced practice registered nurse and physician assistant who regularly treats patients with epilepsy shall provide each such patient with information concerning the risk of sudden unexpected death in epilepsy and methods to mitigate such risk.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-38

Sec. 2	*from passage*	New section
Sec. 3	*July 1, 2025*	New section
Sec. 4	*July 1, 2025*	New section
Sec. 5	*July 1, 2025*	New section
Sec. 6	*July 1, 2025*	New section
Sec. 7	*July 1, 2025*	New section
Sec. 8	*July 1, 2025*	New section
Sec. 9	*July 1, 2025*	New section
Sec. 10	*July 1, 2025*	New section
Sec. 11	*July 1, 2025*	New section
Sec. 12	*July 1, 2025*	New section
Sec. 13	*July 1, 2025*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	17a-667a(f)
Sec. 16	*from passage*	New section
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	New section
Sec. 22	*October 1, 2025*	New section
Sec. 23	*October 1, 2025*	New section
Sec. 24	*October 1, 2025*	New section
Sec. 25	*October 1, 2025*	New section
Sec. 26	*October 1, 2025*	19a-88(e)(1)
Sec. 27	*July 1, 2025*	New section

Statement of Legislative Commissioners:

In Sec. 13(a)(1), "or gender-affirming health care services" was inserted after "reproductive health care services" for consistency with the provisions of subsection (b) of said section.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Public Health, Dept.	GF - Cost	35.3 million	305,000
Public Health, Dept.	GF - Revenue Gain	See Below	See Below
Education, Dept.	GF - Cost	3.6 million	None
State Comptroller - Fringe Benefits[1]	GF - Cost	90,600	124,100

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 26 $	FY 27 $
Municipal Water Companies	Potential Cost/Savings	See Below	See Below

Explanation

The bill contains various provisions regarding healthcare and healthcare services, which result in the fiscal impacts described below.

Resulting costs include $38.6 million appropriated to support new programs or accounts in FY 26, along with $346,400 in FY 26 and $428,900 in FY 27 associated with expanded Department of Public Health (DPH) oversight of hospitals and creation of a new DPH licensure category.

Section 1 makes technical changes regarding water fluoridation

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 40.71% of payroll in FY 26.

standard levels and results in no state fiscal impact. However, this provision may result in a potential cost or savings to municipal water companies beginning in FY 26 to the extent that the bill requires more or less fluoride to be added to the water.

Section 2, which allows DPH to create an advisory committee on matters related to federal Centers for Disease Control and Prevention and Food and Drug Administration recommendations, results in no fiscal impact. DPH has sufficient expertise to assist the committee in its work.

Section 3, which sets limitations on health care entities' ability to discipline providers for actions related to reproductive, gender-affirming, or emergency health care services, results in no fiscal impact to the state.

Sections 4 - 11 incorporate into state law similar provisions as those in the federal Emergency Medical Treatment and Labor Act (EMTALA), requiring: (1) hospitals to adopt certain policies; and (2) DPH to exercise oversight responsibilities, including reviewing reports, conducting investigations, and developing regulations. This results in an estimated cost to DPH of $86,000 in FY 26 and $112,000 in FY 27 (and annually thereafter), with an estimated cost to the Office of the State Comptroller for associated fringe benefits of $33,300 in FY 26 and $45,600 in FY 27. FY 26 costs reflect an October 1 start date for all staff.

DPH will require: (1) a 0.25 FTE IT Subject Matter Expert at an annualized salary of $30,700 (plus $12,500 annualized fringe benefits) to design, develop and maintain electronic submission portals for reporting; (2) a 0.25 FTE Health Program Assistant at an annualized salary of $14,400 (plus $5,900 annualized fringe benefits) to monitor compliance with reporting requirements; and (3) a 0.25 FTE Supervising Nurse Consultant at an annualized salary of $23,800 (plus $9,700 annualized fringe benefits) to support the development of regulations and compliance enforcement.

DPH also has investigative authority over any alleged violations of

relevant sections within the bill. A half-time Staff Attorney 1, at an annualized salary of $42,900 (plus $17,500 annualized fringe benefits), will be required to support DPH's Facility Licensing and Investigations Section (FLIS) in associated disciplinary actions.

FLIS currently conducts federal investigations on behalf of the Centers for Medicare and Medicaid Services, assessing compliance with EMTALA and federal regulations.[2] Any legal disputes concerning the EMTALA investigations are managed by federally funded attorneys employed by DPH. These staff cannot handle state investigations under their respective funding agreements.

To support this work, DPH will incur a one-time equipment cost of $4,200 in FY 26 for a laptop and office supplies, as well as an ongoing cost of $200 annually, starting in FY 27, for software and office supplies.

Section 12 allows an individual harmed by a violation of Sections 4 - 11 to sue a hospital or other health entity, and results in no state fiscal impact. The court system disposes of over 250,000 cases annually and the number of cases is not anticipated to be great enough to need additional resources.

Section 13 establishes a "safe harbor account" as a separate, nonlapsing, account of the Office of the State Treasurer. Any expenditures from the account, as directed by an associated board of trustees, would be contingent upon revenues being made available for such purpose. The bill does not specify any related state or municipal revenue source, but authorizes the account to receive private funding. Should funding become available, administration of grants in accordance with the bill's provisions is expected to be fulfilled within the current resources of the State Treasurer.

Sections 14 and 15, which declare opioid use disorder to be a public health crisis and require the Alcohol and Drug Policy Council to convene a working group to set goals to combat this disorder's

[2] In calendar year 2023, FLIS conducted 1 EMTALA investigation. In calendar year 2024, 2 EMTALA investigations were conducted.

prevalence, result in no fiscal impact.

Sections 16 and 17 appropriate $3.6 million in FY 26 from the General Fund to the State Department of Education to establish a mental and behavioral health awareness and treatment pilot program in Priority School Districts. The funding will be used to purchase an electronic tool that provides mental and behavioral health resources and support.

Sections 18 and 19 create a public health urgent communication account as a separate, nonlapsing account, and appropriate $5 million in FY 26 from the General Fund to DPH for the account. DPH must use the account's funds to give timely, effective communication to the public, health care providers, and other stakeholders during a governor-declared public health emergency.

Sections 20 and 21 create an emergency public health financial safeguard account as a separate, nonlapsing account, and appropriate $30 million in FY 26 from the General Fund to DPH for the account. DPH must use the account's funds to (1) address unexpected shortfalls in public health funding, and (2) ensure the department's ability to respond to the state's health care needs and provide essential public health services.

Sections 22 - 26 create a new DPH licensure category for health care administrators. This results in an additional estimated cost to the agency of $170,000 in FY 26 and $193,000 in FY 27 (and annually thereafter), with an estimated cost to the Office of the State Comptroller for associated fringe benefits of $57,300 in FY 26 and $78,500 in FY 27. FY 26 costs reflect an October 1 start date for all staff. These sections also result in a revenue gain beginning in FY 26.

It is anticipated that DPH will hire one full-time Licensing and Application Analyst at an annualized salary of $78,000 (with $31,800 in annualized fringe benefits) to develop and maintain the licensure application.

As part of establishing licensure requirements, the bill directs DPH

to design an exam to test an applicant's knowledge of health care laws, patient safety protocols and health-related ethical guidelines.[3] The expertise of a health care consultant, at an estimated cost of $20,800 in FY 26, is required to help develop this exam.

The bill also provides jurisdiction to DPH to hear all charges of unacceptable conduct against a person licensed as a healthcare administrator. This requires a full-time Health Program Associate at an annualized salary of $71,700 (plus $29,200 in annualized fringe benefits) to investigate allegations of unacceptable conduct. A half-time Staff Attorney 1, at an annualized salary of $42,900 (plus $17,500 in annualized fringe benefits), will represent FLIS in any violations that result in adjudication as well as hear all charges of unacceptable conduct against a person licensed as a healthcare administrator.

To support this work, DPH will incur a one-time equipment cost of $8,400 in FY 26 for a laptop and related hardware, as well as an ongoing cost of $400 annually, starting in FY 27, for software and office supplies.

The bill establishes licensure fees for this new profession, resulting in a General Fund revenue gain in FY 26 from initial licensure fees ($200 each). A health care administrator license will be subject to annual renewal, resulting in an FY 27 General Fund revenue gain from renewal fees[4] ($105 each), and minimal revenue associated with new entrants to this profession (and annually thereafter). The amount of the revenue gain may exceed $100,000, dependent on the number of initial and renewed licenses.[5]

[3] A review conducted by DPH failed to identify a similar credential in neighboring and nearby states. There does not appear to be an existing model to help develop the design and content of DPH's health care administrator licensure exam, and the department lacks the necessary expertise to meet the bill's requirements.

[4]Of each $105 renewal fee, $100 will be deposited in the General Fund. The remaining $5 fee is deposited into the professional assistance program account which supports the Health Assistance InterVention Education Network (HAVEN).

[5] Connecticut has 27 general hospitals, 3 freestanding emergency departments, and 1 children's hospital. If each such entity has 20 potential licensees, the initial licensure fees will total $124,000; if each has 40 potential licensees, renewal fee revenue will also exceed $100,000.

Additionally, the DPH commissioner is authorized to take disciplinary action against a licensed health care administrator, which may result in a minimal revenue gain to the General Fund from civil penalties beginning in FY 27. Disciplinary actions available to DPH include imposing a civil penalty of up to $10,000. The extent of the revenue gain, if any, is dependent on the number of violations and DPH's discretion regarding civil penalties.

Section 27, which requires certain medical professionals who regularly treat patients with epilepsy to provide them information on sudden unexpected death in epilepsy, results in no state fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 7

AN ACT CONCERNING PROTECTIONS FOR ACCESS TO HEALTH CARE AND THE EQUITABLE DELIVERY OF HEALTH CARE SERVICES IN THE STATE.

TABLE OF CONTENTS:

§§ 16 & 17 — PRIORITY SCHOOL DISTRICT MENTAL HEALTH PILOT PROGRAM

Requires SDE, in consultation with DCF, to create a pilot program in priority school districts on mental and behavioral health awareness and treatment using an online tool; appropriates $3.6 million for FY 26 for this purpose

§§ 18 & 19 — PUBLIC HEALTH URGENT COMMUNICATION ACCOUNT

Creates an account to fund DPH communications during public health emergencies; appropriates $5 million for FY 26 for this purpose

§§ 20 & 21 — EMERGENCY PUBLIC HEALTH FINANCIAL SAFEGUARD ACCOUNT

Creates an account to address unexpected shortfalls in public health funding; appropriates $30 million for FY 26 for this purpose

§§ 22-26 — HOSPITAL ADMINISTRATOR LICENSURE

Creates a DPH licensure program for hospital administrators ("health care administrators"), prohibits unlicensed people from serving in this role, and sets the grounds for disciplinary action (such as fiscal or operational decisions that create an unreasonable risk of patient harm)

§ 27 — SUDEP INFORMATION

Requires physicians, APRNs, and PAs who regularly treat patients with epilepsy to give them information on sudden unexpected death in epilepsy

SUMMARY

This bill makes changes to laws related to emergency medical treatment, reproductive or gender-affirming care, hospital administrators, public health funding, and various other health care-related matters, as explained in the section-by-section analysis that follows.

EFFECTIVE DATE: Various; see below.

§ 1 — WATER FLUORIDATION

Codifies the amount of fluoride that water companies must add to the water supply, rather than tying the amount to federal recommendations

The bill codifies the amount of fluoride that water companies must add to the water supply, rather than tying the amount to federal Department of Health and Human Services (HHS) recommendations as current law does. In doing so, it maintains the current required level.

Specifically, it requires water companies to add enough fluoride to maintain an average monthly fluoride content of 0.7 milligrams per liter (mg/L) (the current HHS recommendation), within a range of 0.15 mg/L greater or lower than this amount. As under current law, the bill applies to water systems that serve at least 20,000 people.

EFFECTIVE DATE: Upon passage

Background — Related Bill

SB 1326 (File 288), favorably reported by the Public Health Committee, contains substantially similar provisions on water fluoridation.

§ 2 — FEDERAL RECOMMENDATION ADVISORY COMMITTEE

Allows DPH to create an advisory committee on matters related to CDC and FDA recommendations

The bill expressly allows the Department of Public Health (DPH) commissioner to create a committee to advise her on matters relating to federal Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA) recommendations, using evidence-based data from peer-reviewed sources. If convened, the committee must serve in a nonbinding advisory capacity, providing guidance solely at the commissioner's discretion.

The committee may include, among others, the following members from in-state higher education institutions:

1. the deans of public health schools at an independent and a public institution,

2. a primary care physician with at least 10 years of clinical experience and who is a medical school professor,

3. an infectious disease specialist with at least 10 years of clinical experience and who is a professor, and

4. a pediatrician with at least 10 years of clinical experience and expertise in children's health and vaccinations and who is professor.

The committee may also include anyone else the commissioner determines would be beneficial.

EFFECTIVE DATE: Upon passage

§§ 3 & 12 — LIMITS ON DISCIPLINING PROVIDERS

Places various limitations on health care entities' ability to discipline providers for actions related to reproductive, gender-affirming, or emergency health care services; creates a private right of action for violations

The bill prohibits health care entities, under certain conditions, from limiting a health care provider's ability to give patients comprehensive, medically accurate information or counseling about reproductive or gender-affirming health care services, or about related community services and resources.

It also prohibits health care entities, under certain conditions, from firing or disciplining a provider for:

1. giving this information or counseling;

2. providing emergency medical services, including reproductive health services; or

3. refusing to transfer a patient when the transfer would jeopardize the patient's condition or recovery chances.

It also specifically prohibits hospital emergency departments, under certain conditions, from prohibiting providers from performing emergency services, including reproductive health care services.

The bill allows someone harmed by a violation of these provisions to sue a hospital or other health entity, and specifies the available court

relief.

Under the bill, health care providers generally are any state-credentialed providers who are employed by, or acting on behalf of, a health care entity.

The bill defines "reproductive health care services" as all medical, surgical, counseling, or referral services related to the reproductive system, including pregnancy, contraception, and pregnancy termination.

"Gender-affirming health care services" include all medical care to treat (1) gender dysphoria, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (the DSM-5-TR), and (2) gender incongruence, as defined in the most recent revision of the International Statistical Classification of Diseases and Related Health Problems.

EFFECTIVE DATE: July 1, 2025

Reproductive or Gender-Affirming Care Information or Counseling

Under certain conditions, the bill prohibits health care entities from limiting a health care provider's ability to give comprehensive, medically accurate and appropriate information and counseling (e.g., information supported by current scientific evidence and published in peer-reviewed journals as appropriate) to patients about:

1. their health status related to gender-affirming or reproductive health care services, including diagnosis, prognosis, treatment recommendations and alternatives, and any potential risk to their life or health, and

2. related community services and resources and how to access them to obtain the care they choose.

For the above prohibitions to apply, the providers must be acting (1) in good faith; (2) within their professional scope of practice, education,

training, and experience (including their specialty and board certification); and (3) within the accepted standard of care.

The bill also specifically prohibits health care entities from firing or disciplining a provider solely for giving this information or counseling.

Under the bill, health care entities may still perform relevant peer reviews of health care providers they employ or require them to (1) comply with preferred provider network or utilization review requirements for insurance purposes or (2) meet established health care quality and patient safety guidelines or rules.

Emergency Medical Services Generally

The bill prohibits health care entities from firing or disciplining a provider for providing emergency medical services, including reproductive health services, if the (1) failure to do so would violate the accepted standard of care and (2) patient is suffering from an emergency medical condition.

Under the bill, "emergency medical services" is the medical screening, examination, and evaluation by a physician or another licensed provider (acting independently or under a physician's supervision when required by law) to determine if an emergency medical condition or active labor exists and, if so, the care, treatment and surgery that is (1) needed to relieve or eliminate the condition and (2) within the scope of the facility's license and the provider's scope of practice. This specifically includes reproductive health care services related to pregnancy complications, including miscarriage management and treating ectopic pregnancies. "Active labor" is labor when (1) there is not enough time to safely transfer the patient to another hospital or (2) a transfer poses a threat to the patient's or fetus's health and safety.

An "emergency medical condition" is one with acute or severe symptoms, including severe pain, where the lack of immediate medical attention could reasonably be thought to lead to (1) placing the patient's life or health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of an organ or another body part.

Emergency Rooms

The bill prohibits hospitals with emergency departments from banning health care providers from providing emergency medical services, including reproductive health care services, to patients with an emergency medical condition, if failing to provide the service would violate accepted standards of care.

For this prohibition to apply, the providers must be acting (1) in good faith; (2) within their professional scope of practice, education, training, and experience; and (3) within the accepted standard of care.

But hospitals may limit a provider's practice to (1) comply with preferred provider network or utilization review requirements or (2) ensure quality and patient safety, including when these issues are identified through peer review.

Transfers

The bill prohibits health care entities from firing or disciplining a provider for refusing to transfer a patient when the provider determines, with reasonable medical probability, that the transfer or resultant delay will create a "medical hazard" (a material decline in or jeopardy to the patient's condition or recovery chances).

For this prohibition to apply, the providers must be acting (1) within their professional scope of practice, education, training, and experience and (2) within the accepted standard of care.

Private Right of Action

The bill allows someone harmed by a violation of these provisions to sue a hospital or other health entity. They must file the suit within 180 days after the violation occurred.

Under the bill, if the entity is found to have committed a violation, it is liable for compensatory damages, with costs and reasonable attorney's fees as the court allows. If the entity retaliated against or otherwise disciplined a provider in violation of the bill, the entity is also liable for the full amount of gross lost wages. The court may also order

injunctive relief to prevent further violations.

If the court determines that a suit for damages was filed without substantial justification, it may instead award costs and reasonable attorney's fees to the health care entity.

The bill specifies that suits filed under this provision may be in addition to any causes of action the law authorizes as well as any actions the state or a profession licensing board may legally take against the heath care entity or provider.

§§ 4-12 — EMTALA

Generally incorporates into state law similar provisions as EMTALA; prohibits hospitals from basing emergency medical services to or discriminating against someone due to several factors

The bill codifies into state law generally similar provisions as the federal Emergency Medical Treatment and Labor Act (EMTALA, see *Background — EMTALA*). In general, these provisions require hospitals to screen and treat patients who present to the emergency department with emergency medical conditions, or arrange for their appropriate transfer, regardless of their ability to pay.

The bill also prohibits hospitals from basing the provision of emergency medical services, or discriminating against anyone, based upon certain attributes described below.

EFFECTIVE DATE: July 1, 2025

Required Emergency Treatment (§ 5)

The bill generally requires each hospital with an emergency department or freestanding emergency department to provide emergency medical services (see above) to anyone requesting them (or anyone for whom these services are requested by someone authorized to act on the person's behalf). This applies if the (1) person has a medical condition placing them in danger of death or serious injury or illness and (2) hospital has appropriate facilities and qualified personnel available. "Qualified personnel" are physicians or other providers, acting within their scope of licensure, with the necessary licensure,

training, education, and experience to provide necessary stabilizing services.

Under the bill, a hospital must provide emergency medical services without first questioning the person's ability to pay. A hospital may follow reasonable registration processes, including asking about insurance, but these questions cannot delay the person's evaluation or emergency services. The registration process also cannot unduly discourage people from staying at the hospital for further evaluation.

The bill immunizes hospitals, their employees, and affiliated providers from civil liability for their refusal to provide emergency medical services if it was based on their determination, while exercising reasonable care, that the (1) person was not experiencing an emergency or (2) hospital does not have the appropriate facilities or qualified personnel available to provide services.

Transfers (§ 6)

The bill prohibits hospitals from transferring anyone needing emergency medical services to another hospital for any nonmedical reason (such as the person's inability to pay) unless the conditions described below have been met. But this does not prevent a patient's voluntary discharge or transfer if the patient (or an authorized representative) gives informed consent to this against medical advice.

The bill requires the DPH commissioner to adopt implementing regulations.

Examination and Evaluation. Before the transfer, a physician must examine and evaluate the person, including engaging in a consultation if necessary. A consultation request can be made by (1) the treating physician or (2) another provider (either independently or under supervision as required by law) with the treating physician's approval.

The consultation must include a review of the patient's medical record. The consulting provider can be off-site.

Emergency Services. The hospital must give the person emergency medical services, including an abortion when medically necessary to stabilize the patient. The hospital must also determine, within reasonable medical probability, that the person's condition has been stabilized and the transfer or resulting delay will not create a medical hazard.

Communication With Receiving Hospital. A physician at the transferring hospital must notify the receiving hospital, and a physician from that hospital must consent to the transfer. The receiving hospital must confirm that the person meets its admissions criteria as to appropriate bed, personnel, and equipment needed for treatment.

Personnel and Equipment. The transferring hospital must provide for appropriate personnel and equipment that a reasonable and prudent physician in the same or similar area exercising ordinary care would use for the transfer.

Medical Records and Test Results. The hospital must compile and transfer the person's pertinent medical records and copies of diagnostic test results that are reasonably available. This may be done through a physical transfer or by confirming that the receiving hospital can access the transferring hospital's electronic records.

Transfer Summary. The transferred records must include a transfer summary, signed by the transferring physician, with relevant available information. The summary form must at least have the:

1. person's name, address, sex, race, age, insurance status, presenting symptoms, and medical condition;

2. name and business address of the transferring physician or emergency department personnel authorizing the transfer, and that person's declaration of being assured, within reasonable medical probability, that the transfer does not create a medical hazard;

3. time and date when the person first presented to the hospital;

4. time, date, and reason for the transfer; and

5. name of the receiving hospital's physician who consented to the transfer, and the time and date of that consent.

The bill specifies that the transfer summary need not contain information that is already in the medical records being transferred.

Contact Person. The hospital must ask the patient if he or she has a preferred contact person to be notified about the transfer. If so, the hospital must make a reasonable attempt to notify that person before the transfer. If the patient is unable to respond, the hospital must make a reasonable effort to determine the identity of the preferred contact person or the next of kin and alert them. The hospital must document these attempts in the patient's medical record.

Receiving Hospital (§ 7)

The bill requires a receiving hospital to accept transfers from a transferring hospital as required by the above provisions or under any contractual obligation to care for the patient. The hospital must provide personnel and equipment reasonably required by the applicable standard of practice and the regulations DPH must adopt (see above) to care for the transferred patient.

Under the bill, if any hospital suffers a financial loss directly due another hospital's improper transfer or refusal to accept a person for whom it has a legal obligation to provide care, the hospital may sue for damages for the financial loss and appropriate equitable relief.

The bill specifies that it does not require a hospital to accept a patient transfer and arrange to care for someone for whom the hospital does not have a legal obligation to provide care.

Conditions of Hospital Licensure (§ 8)

Policies and Protocols. Under the bill, DPH must require, as a condition of a hospital's licensure, that hospitals each adopt policies and transfer protocols consistent with the bill and the required transfer

regulations. Hospitals must collaborate with their medical staff when doing so.

Hospitals must submit (1) these policies and procedures to DPH within 30 days after DPH adopts regulations and (2) any changes to those policies and procedures at least 30 days before they take effect.

Communication With Patients. Under the bill, DPH must also require, as a condition of a hospital's licensure, that each hospital communicate certain information orally and in writing to each person who presents to the hospital's emergency department (or the person's authorized representative, if the representative is present and the person cannot understand this communication). Specifically, the hospital must inform them of the (1) reasons for the transfer or refusal to provide emergency services and (2) person's right, regardless of their ability to pay, to receive stabilizing services before being transferred or discharged.

This pre-transfer notification is not required when (1) notification is impossible due to the person's physical or mental condition, (2) the person is alone, and (3) the hospital made a reasonable effort to locate an authorized representative.

Each hospital must prominently post a sign in its emergency department informing the public about their rights under the bill. Both the written communication and sign must include DPH's contact information and identify DPH as the state agency to contact with complaints about the hospital's conduct.

Recordkeeping and Reporting (§ 9)

The bill requires transferring and receiving hospitals to keep transfer records (including transfer summaries) for at least three years. Hospitals involved in these transfers also must file annual reports with DPH describing the number of transfers made and received, the insurance status of these patients, and the reasons for the transfers.

Reporting Violations and Protection Against Retaliation (§ 9)

The bill requires certain parties to report to DPH if they are aware of an apparent violation of the bill or transfer regulations. This applies to receiving hospitals, their physicians and licensed emergency room personnel, and licensed emergency medical services (EMS) personnel involved in the patient's transfer. It also allows transferring hospitals, physicians, and other providers involved in the transfer to report. They must (or may) report within 14 days after the violation and in a way DPH specifies.

When two or more people required to report both know of an apparent violation, they may make a single report by mutual agreement under hospital protocols. If someone is required to report and disagrees with the joint report, he or she must report individually.

The bill prohibits hospitals, state agencies, or anyone else from taking various actions against physicians, other hospital personnel, or EMS personnel for reporting in good faith an apparent violation to DPH, the hospital, a member of the hospital's medical staff, or any other interested party or government agency. Specifically, they must not retaliate or bring a lawsuit against the person, penalize or recover monetary relief from them, or otherwise cause the person injury.

DPH Investigations and Disciplinary Action (§ 10)

Except as otherwise specified above, DPH must investigate each alleged violation of these provisions or the transfer regulations, unless the commissioner concludes that the (1) facts do not require further investigation or (2) allegation is otherwise without merit.

The bill allows DPH to take disciplinary action, under existing procedures, against hospitals or individual providers. By law, DPH may impose a range of disciplinary actions, such as (1) revoking or suspending a license, (2) issuing a letter of reprimand, (3) placing the institution or person on probationary status, or (4) imposing a civil penalty.

Non-Discrimination (§ 11)

The bill generally prohibits hospitals from basing the emergency

medical services (in whole or in part) they provide to someone, or discriminating against them, based on the person's ethnicity, citizenship, age, preexisting medical condition, insurance or economic status, ability to pay, sex, race, color, religion, disability, genetic information, marital status, sexual orientation, gender identity or expression, primary language, or immigration status. But this does not apply to the extent that a circumstance like age, sex, pregnancy, a medical condition related to childbirth, a preexisting medical condition, or physical or mental disability is medically significant to providing appropriate patient care.

Under the bill, unless a contract allows otherwise, hospitals must prohibit their on-call emergency department physicians from refusing to respond to a call based on most of the factors listed above or the person's current medical condition. If a contract that existed before July 1, 2025, between a physician and hospital for emergency department coverage prevents a hospital from imposing this prohibition, the parties must revise the contract to include it as soon as they legally can do so. The bill specifies that it does not require any physician to serve in an on-call role at a hospital.

The bill requires each hospital to adopt a policy to implement these provisions.

Private Right of Action (§ 12)

The bill allows an individual harmed by a violation of these provisions to sue (see *Private Right of Action* subheading under §§ 3 & 12, above).

Background — EMTALA

EMTALA requires every hospital with an emergency department that participates in Medicare to screen and treat patients with emergency medical conditions or arrange for their appropriate transfer if they are unable to do so. They must do this regardless of a person's income, insurance status, or other factors (e.g., immigration status, race, or religion). Hospitals and providers who fail to comply are subject to

civil penalties and termination from Medicare or Medicaid (42 U.S.C. § 1395dd and 42 C.F.R. § 1003.500).

Background — Related Bills

sHB 7157, § 18, favorably reported by the Public Health Committee, increases the maximum civil penalty that DPH may impose against DPH-credentialed individuals from $10,000 to $25,000.

sSB 1380, favorably reported by the Judiciary Committee, prohibits health care providers from knowingly discriminating in providing health care services due to several factors (similar to those under § 11 of this bill).

§ 13 — SAFE HARBOR ACCOUNT

Creates an account funded by private sources to award grants to providers of reproductive or gender-affirming health care services and to nonprofit organizations who help pay certain costs for people who come to Connecticut to get these services

The bill creates the "safe harbor account" related to reproductive and gender-affirming health care. The account is a separate, nonlapsing account of the state treasurer and administered by a board of trustees, and must contain funds received from private sources (e.g., gifts, grants, or donations).

The board must spend the account's funds to award grants, in line with policies and procedures it adopts, to the following:

1. providers of reproductive or gender-affirming health care services;

2. nonprofits whose mission includes funding reproductive health care services or the collateral costs (such as travel, lodging, or meals, but not the procedure itself) people incur receiving these services in the state, when they are from states limiting their access to these services ("qualified people"); or

3. nonprofits that serve LGBTQ+ youth or families in the state for the purpose of reimbursing or paying for qualified people's collateral costs to receive reproductive or gender-affirming

health care services.

EFFECTIVE DATE: July 1, 2025

Board of Trustees

Under the bill, the safe harbor account is administered by a board of trustees with the following nine members:

1. the state treasurer or his designee (who serves as the board's chairperson);

2. the commissioners of DPH, mental health and addiction services, and social services, or their designees; and

3. five treasurer-appointed members, including (a) one in-state provider of reproductive health care services, (b) one person experienced in working with the LGBTQ+ community, and (c) one person experienced in working with reproductive health care providers.

When making his appointments, the treasurer must use his best efforts to ensure that the board reflects the state's racial, gender, and geographic diversity.

Board Policies and Procedures

The bill requires the board of trustees, by September 1, 2025, to adopt policies and procedures on awarding these grants, including (1) application procedures; (2) eligibility criteria (including for collateral costs); (3) considerations of need, including an applicant's financial need; and (4) ways to coordinate with any national network that performs similar functions, including on accepting funding transferred to the account for a particular use. The policies and procedures must not condition grant eligibility on the collection or retention of patient-identifiable data.

The bill allows the board, as it deems necessary, to update the policies and procedures. It also allows the board to make a fact-based eligibility determination if it decides that the policies and procedures are

inadequate to determine (1) a particular provider's or organization's eligibility or (2) whether a provider or nonprofit may use grant money to reimburse or pay for a certain service or collateral cost.

§§ 14 & 15 — OPIOID USE DISORDER

Declares opioid use disorder to be a public health crisis in the state and requires the Alcohol and Drug Policy Council to convene a working group to set goals to combat this disorder's prevalence

The bill requires the state's Alcohol and Drug Policy Council to convene a working group to set one or more goals for the state in its efforts to combat the prevalence of opioid use disorder. The council must report on these goals to the Public Health Committee by January 1, 2026.

The bill also declares that opioid use disorder is a public health crisis in Connecticut and will continue as one until the state meets the working group's goals.

EFFECTIVE DATE: Upon passage

§§ 16 & 17 — PRIORITY SCHOOL DISTRICT MENTAL HEALTH PILOT PROGRAM

Requires SDE, in consultation with DCF, to create a pilot program in priority school districts on mental and behavioral health awareness and treatment using an online tool; appropriates $3.6 million for FY 26 for this purpose

The bill requires the state Department of Education (SDE) to create a pilot program to allow at least 100,000 students in priority school districts (see *Background – Priority School Districts*) to use an electronic mental and behavioral health awareness and treatment tool (through a website, mobile application, or other online service). SDE must create the program by January 1, 2026, and in consultation with the Department of Children and Families (DCF). The SDE commissioner must select the tool to be used in the program.

The bill appropriates $3.6 million from the General Fund to SDE for FY 26 to administer the program.

EFFECTIVE DATE: Upon passage

Program Components

Under the bill, the pilot program's chosen electronic tool must provide mental and behavioral health education resources to promote awareness and understanding of these issues. It also must include peer-to-peer support services, including an online peer chat room to encourage students' social connection and mutual support. A moderator must prescreen and filter students' comments before they are posted.

The chosen tool must also include private online sessions with state-licensed mental or behavioral health care providers selected or approved by the SDE commissioner. These professionals must be experienced in delivering services in both rural and urban school districts. These sessions must comply with the state's laws on (1) telehealth and (2) parental consent and notification regarding a minor's outpatient mental health treatment (see *Background — Outpatient Mental Health Treatment for Minors*).

Program Objectives and Reporting

Under the bill, during the program's first year, its objectives are to (1) build partnerships between priority school districts and community organizations providing mental and behavioral health care services and (2) launch a digital marketing campaign using tools, including a geofence, to raise awareness and engagement among students about these issues. (Generally, a geofence is technology that uses GPS coordinates or other local detection to create a virtual boundary.)

During the program's second year, its objectives are to (1) refer students to mental and behavioral health care providers, as needed, and (2) enhance students' engagement with mental and behavioral health tools, including coping strategies and clinician support.

By January 1, 2026, and again by January 1, 2027, the bill requires the SDE commissioner to report to the Public Health and Education committees on the program's success in achieving these objectives.

Background — Priority School Districts

Priority school districts are districts (1) whose students receive low standardized test scores, (2) that have high levels of poverty, or (3) in the eight towns with the largest populations in the state. There are 16 priority school districts in the 2024-25 school year.

Background — Outpatient Mental Health Treatment for Minors

By law, parental consent or notification is not required for a minor to request and receive outpatient mental health treatment (not including prescribing legend drugs) under certain circumstances. Among other things, the provider must determine that (1) the treatment is clinically indicated, (2) requiring parental consent or notification would cause the minor to reject the treatment, and (3) the minor is mature enough to participate in the treatment productively.

Under the law, a provider may notify a parent or guardian of this treatment without the minor's consent or notification if the (1) provider determines that notification or disclosure is necessary for the minor's well-being, (2) treatment is solely for mental health and not for a substance use disorder, and (3) minor is given an opportunity to object to the notification or disclosure.

§§ 18 & 19 — PUBLIC HEALTH URGENT COMMUNICATION ACCOUNT

Creates an account to fund DPH communications during public health emergencies; appropriates $5 million for FY 26 for this purpose

The bill creates the public health urgent communication account as a separate, nonlapsing account, and appropriates $5 million from the General Fund to DPH for FY 26 for it. The account must contain any money required by law to be deposited into it.

Under the bill, DPH must use the account's funds to give the public, health care providers, and other stakeholders timely, effective communication during a governor-declared public health emergency.

EFFECTIVE DATE: Upon passage

§§ 20 & 21 — EMERGENCY PUBLIC HEALTH FINANCIAL SAFEGUARD ACCOUNT

Creates an account to address unexpected shortfalls in public health funding; appropriates $30 million for FY 26 for this purpose

The bill creates the emergency public health financial safeguard account as a separate, nonlapsing account, and appropriates $30 million from the General Fund to DPH for FY 26 for it. The account must contain any money required by law to be deposited into it.

Under the bill, DPH must use the account's funds to (1) address unexpected shortfalls in public health funding and (2) ensure the department's ability to respond to the state's health care needs and provide essential public health services.

EFFECTIVE DATE: Upon passage

§§ 22-26 — HOSPITAL ADMINISTRATOR LICENSURE

Creates a DPH licensure program for hospital administrators ("health care administrators"), prohibits unlicensed people from serving in this role, and sets the grounds for disciplinary action (such as fiscal or operational decisions that create an unreasonable risk of patient harm)

The bill creates a DPH licensure program for hospital administrators ("health care administrators") and sets the criteria for licensure and disciplinary action.

It prohibits anyone without this license from (1) practicing as a health care administrator; (2) referring to themselves with that title; or (3) using any title, words, letters, or abbreviations indicating or implying that the person has this license.

EFFECTIVE DATE: October 1, 2025

Health Care Administrator Defined (§ 22)

Under the bill, a health care administrator is a nonclinical hospital employee who is either a (1) manager with direct supervisory authority over clinical providers or (2) director, officer, or executive with direct or indirect supervisory authority over only these nonclinical hospital managers. To be considered a health care administrator under the bill, these employees must also be responsible for certain activities.

The former must be responsible for one or more of the following:

1. hiring, scheduling, evaluating, and directly supervising clinical providers;

2. monitoring the hospital's compliance with state or federal regulatory requirements; or

3. developing fiscal reports for clinical units or the whole hospital.

The latter must supervise nonclinical managers in one or more of the following:

1. hiring and supervising these managers,

2. overseeing the hospital's (or any department's) operations,

3. setting policies and procedures for patient care standards,

4. overseeing budgetary and financial decisions related to operations and patient care for the hospital or any departments, and

5. ensuring that hospital policies comply with state and federal regulatory requirements.

Standard Licensure and Licensure Without Examination (§ 24)

To qualify for licensure under the bill, applicants generally must meet the following criteria:

1. have a bachelor's or graduate degree in health care administration, public health, or a related field from a regionally accredited higher education institution or from a degree-granting institution in another country and

2. pass a DPH-prescribed exam that tests the applicant's knowledge of health care laws, patient safety protocols, and health-related ethical guidelines.

DPH must grant a license to applicants who show evidence of having met these criteria, submit a complete application, and pay a $200 initial

licensure fee.

The bill also allows DPH to grant a health care administrator license without examination to applicants who are licensed or certified in another U.S. state, territory, or commonwealth. An applicant can obtain a license in this way if the other jurisdiction's licensing standards are at least as strict as Connecticut's. Applicants must pay the same $200 fee as other applicants.

DPH may not grant this license to anyone who has pending disciplinary actions or unresolved complaints against them.

License Renewal (§§ 24 & 26)

Under the bill, the license is valid for one year and is renewable annually during the licensee's birth month. The renewal fee is $105. Renewal applicants must give evidence of having completed continuing education requirements set by the DPH commissioner.

The bill requires the commissioner to adopt regulations setting these requirements, defining qualifying programs, setting a control and reporting system, and allowing for continuing education waivers for good cause.

Enforcement and Disciplinary Action (§ 25)

The bill gives DPH jurisdiction to hear charges that health care administrator licensees engaged in unacceptable conduct. The commissioner must give the licensee 30 days' written notice about the hearing on the charges, and after the hearing, may take disciplinary action against a health care administrator for any of the following:

1. a fiscal or operational decision that led to a patient's injury or created an unreasonable risk of patient harm;

2. a licensed health care provider's violation of a state or federal law or rule regulating a profession when the administrator was responsible for the provider's oversight;

3. aiding or abetting a provider in practicing his or her profession

after a patient complaint or adverse event was reported to the hospital, DPH, or the appropriate disciplining authority, while the complaint or event was being investigated, and if patient harm, disability, or death occurred after the complaint or report;

4. failure to adequately supervise clinical and nonclinical staff to the extent that a patient's health or safety was at risk;

5. any administrative, operational, or fiscal decision that impeded a clinical provider from following practice standards or led to patient harm, disability or death; or

6. a fiscal or operational decision that resulted in clinical providers being unable to practice with reasonable skill and safety, regardless of whether patients were harmed.

By law, disciplinary actions available to DPH include, among other things, (1) revoking or suspending a license, (2) issuing a letter of reprimand, (3) placing the person on probationary status, or (4) imposing a civil penalty.

Under the bill, the commissioner may order a licensee to undergo a reasonable physical or mental examination if his or her capacity to practice safely is under investigation. The commissioner may petition Hartford Superior Court to enforce an examination order or any DPH disciplinary action.

The bill allows anyone aggrieved by the department's findings to appeal to Superior Court, and the appeal must take priority over nonprivileged cases when setting the order of trial.

§ 27 — SUDEP INFORMATION

Requires physicians, APRNs, and PAs who regularly treat patients with epilepsy to give them information on sudden unexpected death in epilepsy

Starting October 1, 2025, the bill requires physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) who regularly treat patients with epilepsy to inform them about sudden unexpected death in epilepsy (SUDEP, which is death among people

with epilepsy not caused by injury, drowning, or other known unrelated causes). Specifically, they must give them information on the risks of SUDEP and ways to mitigate those risks.

EFFECTIVE DATE: July 1, 2025

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 21 Nay 10 (03/27/2025)