General Assembly

Committee Bill No. 7

January Session, 2025

LCO No. **6182**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

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:

1 Section 1. Section 19a-38 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2025*):

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

13 Sec. 2. (NEW) (*Effective from passage*) (a) The Commissioner of Public
14 Health may establish an advisory committee to advise the commissioner
15 on matters relating to recommendations by the Centers for Disease

16 Control and Prevention and the federal Food and Drug Administration
17 using evidence-based data from peer-reviewed literature and studies.

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

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

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

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

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

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

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

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

39 Sec. 3. Section 19a-508c of the general statutes is repealed and the
40 following is substituted in lieu thereof (*Effective July 1, 2025*):

41 (a) As used in this section:

42 (1) "Affiliated provider" means a provider that is: (A) Employed by a

43 hospital or health system, (B) under a professional services agreement
44 with a hospital or health system that permits such hospital or health
45 system to bill on behalf of such provider, or (C) a clinical faculty member
46 of a medical school, as defined in section 33-182aa, that is affiliated with
47 a hospital or health system in a manner that permits such hospital or
48 health system to bill on behalf of such clinical faculty member;

49 (2) "Campus" means: (A) The physical area immediately adjacent to a
50 hospital's main buildings and other areas and structures that are not
51 strictly contiguous to the main buildings but are located within two
52 hundred fifty yards of the main buildings, or (B) any other area that has
53 been determined on an individual case basis by the Centers for Medicare
54 and Medicaid Services to be part of a hospital's campus;

55 (3) "Facility fee" means any fee charged or billed by a hospital or
56 health system for outpatient services provided in a hospital-based
57 facility that is: (A) Intended to compensate the hospital or health system
58 for the operational expenses of the hospital or health system, and (B)
59 separate and distinct from a professional fee;

60 (4) "Health care provider" means an individual, entity, corporation,
61 person or organization, whether for-profit or nonprofit, that furnishes,
62 bills or is paid for health care service delivery in the normal course of
63 business, including, but not limited to, a health system, a hospital, a
64 hospital-based facility, a freestanding emergency department and an
65 urgent care center;

66 (5) "Health system" means: (A) A parent corporation of one or more
67 hospitals and any entity affiliated with such parent corporation through
68 ownership, governance, membership or other means, or (B) a hospital
69 and any entity affiliated with such hospital through ownership,
70 governance, membership or other means;

71 (6) "Hospital" has the same meaning as provided in section 19a-490;

72 (7) "Hospital-based facility" means a facility that is owned or

73 operated, in whole or in part, by a hospital or health system where
74 hospital or professional medical services are provided;

75 (8) "Medicaid" means the program operated by the Department of
76 Social Services pursuant to section 17b-260 and authorized by Title XIX
77 of the Social Security Act, as amended from time to time;

78 (9) "Observation" means services furnished by a hospital on the
79 hospital's campus, regardless of length of stay, including use of a bed
80 and periodic monitoring by the hospital's nursing or other staff to
81 evaluate an outpatient's condition or determine the need for admission
82 to the hospital as an inpatient;

83 (10) "Payer mix" means the proportion of different sources of
84 payment received by a hospital or health system, including, but not
85 limited to, Medicare, Medicaid, other government-provided insurance,
86 private insurance and self-pay patients;

87 (11) "Professional fee" means any fee charged or billed by a provider
88 for professional medical services provided in a hospital-based facility;

89 (12) "Provider" means an individual, entity, corporation or health
90 care provider, whether for profit or nonprofit, whose primary purpose
91 is to provide professional medical services; and

92 (13) "Tagline" means a short statement written in a non-English
93 language that indicates the availability of language assistance services
94 free of charge.

95 (b) If a hospital or health system charges a facility fee utilizing a
96 current procedural terminology evaluation and management (CPT
97 E/M) code, [or] assessment and management (CPT A/M) code,
98 injection and infusion (CPT) code or drug administration (CPT) code for
99 outpatient services provided at a hospital-based facility where a
100 professional fee is also expected to be charged, the hospital or health
101 system shall provide the patient with a written notice that includes the
102 following information:

103 (1) That the hospital-based facility is part of a hospital or health
104 system and that the hospital or health system charges a facility fee that
105 is in addition to and separate from the professional fee charged by the
106 provider;

107 (2) (A) The amount of the patient's potential financial liability,
108 including any facility fee likely to be charged, and, where professional
109 medical services are provided by an affiliated provider, any professional
110 fee likely to be charged, or, if the exact type and extent of the
111 professional medical services needed are not known or the terms of a
112 patient's health insurance coverage are not known with reasonable
113 certainty, an estimate of the patient's financial liability based on typical
114 or average charges for visits to the hospital-based facility, including the
115 facility fee, (B) a statement that the patient's actual financial liability will
116 depend on the professional medical services actually provided to the
117 patient, (C) an explanation that the patient may incur financial liability
118 that is greater than the patient would incur if the professional medical
119 services were not provided by a hospital-based facility, and (D) a
120 telephone number the patient may call for additional information
121 regarding such patient's potential financial liability, including an
122 estimate of the facility fee likely to be charged based on the scheduled
123 professional medical services; and

124 (3) That a patient covered by a health insurance policy should contact
125 the health insurer for additional information regarding the hospital's or
126 health system's charges and fees, including the patient's potential
127 financial liability, if any, for such charges and fees.

128 (c) If a hospital or health system charges a facility fee without
129 utilizing a current procedural terminology evaluation and management
130 (CPT E/M) code<u>, assessment and management (CPT A/M) code,</u>
131 <u>injection and infusion (CPT) code or drug administration (CPT) code</u> for
132 outpatient services provided at a hospital-based facility, located outside
133 the hospital campus, the hospital or health system shall provide the
134 patient with a written notice that includes the following information:

135 (1) That the hospital-based facility is part of a hospital or health
136 system and that the hospital or health system charges a facility fee that
137 may be in addition to and separate from the professional fee charged by
138 a provider;

139 (2) (A) A statement that the patient's actual financial liability will
140 depend on the professional medical services actually provided to the
141 patient, (B) an explanation that the patient may incur financial liability
142 that is greater than the patient would incur if the hospital-based facility
143 was not hospital-based, and (C) a telephone number the patient may call
144 for additional information regarding such patient's potential financial
145 liability, including an estimate of the facility fee likely to be charged
146 based on the scheduled professional medical services; and

147 (3) That a patient covered by a health insurance policy should contact
148 the health insurer for additional information regarding the hospital's or
149 health system's charges and fees, including the patient's potential
150 financial liability, if any, for such charges and fees.

151 (d) Each initial billing statement that includes a facility fee shall: (1)
152 Clearly identify the fee as a facility fee that is billed in addition to, or
153 separately from, any professional fee billed by the provider; (2) provide
154 the corresponding Medicare facility fee reimbursement rate for the same
155 service as a comparison or, if there is no corresponding Medicare facility
156 fee for such service, (A) the approximate amount Medicare would have
157 paid the hospital for the facility fee on the billing statement, or (B) the
158 percentage of the hospital's charges that Medicare would have paid the
159 hospital for the facility fee; (3) include a statement that the facility fee is
160 intended to cover the hospital's or health system's operational expenses;
161 (4) inform the patient that the patient's financial liability may have been
162 less if the services had been provided at a facility not owned or operated
163 by the hospital or health system; and (5) include written notice of the
164 patient's right to request a reduction in the facility fee or any other
165 portion of the bill and a telephone number that the patient may use to
166 request such a reduction without regard to whether such patient

167 qualifies for, or is likely to be granted, any reduction. Not later than
168 October 15, 2022, and annually thereafter, each hospital, health system
169 and hospital-based facility shall submit to the Health Systems Planning
170 Unit of the Office of Health Strategy a sample of a billing statement
171 issued by such hospital, health system or hospital-based facility that
172 complies with the provisions of this subsection and which represents
173 the format of billing statements received by patients. Such billing
174 statement shall not contain patient identifying information.

175 (e) The written notice described in subsections (b) to (d), inclusive,
176 and (h) to (j), inclusive, of this section shall be in plain language and in
177 a form that may be reasonably understood by a patient who does not
178 possess special knowledge regarding hospital or health system facility
179 fee charges. On and after October 1, 2022, such notices shall include tag
180 lines in at least the top fifteen languages spoken in the state indicating
181 that the notice is available in each of those top fifteen languages. The
182 fifteen languages shall be either the languages in the list published by
183 the Department of Health and Human Services in connection with
184 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-
185 148, or, as determined by the hospital or health system, the top fifteen
186 languages in the geographic area of the hospital-based facility.

187 (f) (1) For nonemergency care, if a patient's appointment is scheduled
188 to occur ten or more days after the appointment is made, such written
189 notice shall be sent to the patient by first class mail, encrypted electronic
190 mail or a secure patient Internet portal not less than three days after the
191 appointment is made. If an appointment is scheduled to occur less than
192 ten days after the appointment is made or if the patient arrives without
193 an appointment, such notice shall be hand-delivered to the patient when
194 the patient arrives at the hospital-based facility.

195 (2) For emergency care, such written notice shall be provided to the
196 patient as soon as practicable after the patient is stabilized in accordance
197 with the federal Emergency Medical Treatment and Active Labor Act,
198 42 USC 1395dd, as amended from time to time, or is determined not to

199 have an emergency medical condition and before the patient leaves the
200 hospital-based facility. If the patient is unconscious, under great duress
201 or for any other reason unable to read the notice and understand and
202 act on his or her rights, the notice shall be provided to the patient's
203 representative as soon as practicable.

204 (g) Subsections (b) to (f), inclusive, and (l) of this section shall not
205 apply if a patient is insured by Medicare or Medicaid or is receiving
206 services under a workers' compensation plan established to provide
207 medical services pursuant to chapter 568.

208 (h) A hospital-based facility shall prominently display written notice
209 in locations that are readily accessible to and visible by patients,
210 including patient waiting or appointment check-in areas, stating: (1)
211 That the hospital-based facility is part of a hospital or health system, (2)
212 the name of the hospital or health system, and (3) that if the hospital-
213 based facility charges a facility fee, the patient may incur a financial
214 liability greater than the patient would incur if the hospital-based
215 facility was not hospital-based. On and after October 1, 2022, such
216 notices shall include tag lines in at least the top fifteen languages spoken
217 in the state indicating that the notice is available in each of those top
218 fifteen languages. The fifteen languages shall be either the languages in
219 the list published by the Department of Health and Human Services in
220 connection with section 1557 of the Patient Protection and Affordable
221 Care Act, P.L. 111-148, or, as determined by the hospital or health
222 system, the top fifteen languages in the geographic area of the hospital-
223 based facility. Not later than October 1, 2022, and annually thereafter,
224 each hospital-based facility shall submit a copy of the written notice
225 required by this subsection to the Health Systems Planning Unit of the
226 Office of Health Strategy.

227 (i) A hospital-based facility shall clearly hold itself out to the public
228 and payers as being hospital-based, including, at a minimum, by stating
229 the name of the hospital or health system in its signage, marketing
230 materials, Internet web sites and stationery.

231 (j) A hospital-based facility shall, when scheduling services for which
232 a facility fee may be charged, inform the patient (1) that the hospital-
233 based facility is part of a hospital or health system, (2) of the name of the
234 hospital or health system, (3) that the hospital or health system may
235 charge a facility fee in addition to and separate from the professional fee
236 charged by the provider, and (4) of the telephone number the patient
237 may call for additional information regarding such patient's potential
238 financial liability.

239 (k) (1) If any transaction described in subsection (c) of section 19a-
240 486i results in the establishment of a hospital-based facility at which
241 facility fees may be billed, the hospital or health system, that is the
242 purchaser in such transaction shall, not later than thirty days after such
243 transaction, provide written notice, by first class mail, of the transaction
244 to each patient served within the three years preceding the date of the
245 transaction by the health care facility that has been purchased as part of
246 such transaction.

247 (2) Such notice shall include the following information:

248 (A) A statement that the health care facility is now a hospital-based
249 facility and is part of a hospital or health system, the health care facility's
250 full legal and business name and the date of such facility's acquisition
251 by a hospital or health system;

252 (B) The name, business address and phone number of the hospital or
253 health system that is the purchaser of the health care facility;

254 (C) A statement that the hospital-based facility bills, or is likely to bill,
255 patients a facility fee that may be in addition to, and separate from, any
256 professional fee billed by a health care provider at the hospital-based
257 facility;

258 (D) (i) A statement that the patient's actual financial liability will
259 depend on the professional medical services actually provided to the
260 patient, and (ii) an explanation that the patient may incur financial

261 liability that is greater than the patient would incur if the hospital-based
262 facility were not a hospital-based facility;

263 (E) The estimated amount or range of amounts the hospital-based
264 facility may bill for a facility fee or an example of the average facility fee
265 billed at such hospital-based facility for the most common services
266 provided at such hospital-based facility; and

267 (F) A statement that, prior to seeking services at such hospital-based
268 facility, a patient covered by a health insurance policy should contact
269 the patient's health insurer for additional information regarding the
270 hospital-based facility fees, including the patient's potential financial
271 liability, if any, for such fees.

272 (3) A copy of the written notice provided to patients in accordance
273 with this subsection shall be filed with the Health Systems Planning
274 Unit of the Office of Health Strategy, established under section 19a-612.
275 Said unit shall post a link to such notice on its Internet web site.

276 (4) A hospital, health system or hospital-based facility shall not collect
277 a facility fee for services provided at a hospital-based facility that is
278 subject to the provisions of this subsection from the date of the
279 transaction until at least thirty days after the written notice required
280 pursuant to this subsection is mailed to the patient or a copy of such
281 notice is filed with the Health Systems Planning Unit of the Office of
282 Health Strategy, whichever is later. A violation of this subsection shall
283 be considered an unfair trade practice pursuant to section 42-110b.

284 (5) Not later than July 1, 2023, and annually thereafter, each hospital-
285 based facility that was the subject of a transaction, as described in
286 subsection (c) of section 19a-486i, during the preceding calendar year
287 shall report to the Health Systems Planning Unit of the Office of Health
288 Strategy the number of patients served by such hospital-based facility
289 in the preceding three years.

290 (l) (1) Notwithstanding the provisions of this section, no hospital,

health system or hospital-based facility shall collect a facility fee for (A) outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code, **[**or**]** assessment and management (CPT A/M) code, injection and infusion (CPT) code or drug administration (CPT) code and are provided at a hospital-based facility located off-site from a hospital campus, or (B) outpatient health care services provided at a hospital-based facility located off-site from a hospital campus received by a patient who is uninsured of more than the Medicare rate.

(2) Notwithstanding the provisions of this section, on and after July 1, 2024, no hospital or health system shall collect a facility fee for outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code and are provided on the hospital campus. The provisions of this subdivision shall not apply to (A) an emergency department located on a hospital campus, or (B) observation stays on a hospital campus and (CPT E/M) and (CPT A/M) codes when billed for the following services: (i) Wound care, (ii) orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi) solid organ transplant.

(3) Notwithstanding the provisions of subdivisions (1) and (2) of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of subdivision (1) of this subsection, and in circumstances when an insurance contract that is in effect on July 1, 2024, provides reimbursement for facility fees prohibited under the provisions of subdivision (2) of this subsection, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the applicable date of expiration, renewal or amendment of such contract, whichever such date is the earliest.

(4) The provisions of this subsection shall not apply to a freestanding emergency department. As used in this subdivision, "freestanding

323 emergency department" means a freestanding facility that (A) is
324 structurally separate and distinct from a hospital, (B) provides
325 emergency care, (C) is a department of a hospital licensed under chapter
326 368v, and (D) has been issued a certificate of need to operate as a
327 freestanding emergency department pursuant to chapter 368z.

328 (5) (A) On and after July 1, 2024, if the Commissioner of Health
329 Strategy receives information and has a reasonable belief, after
330 evaluating such information, that any hospital, health system or
331 hospital-based facility charged facility fees, other than through isolated
332 clerical or electronic billing errors, in violation of any provision of this
333 section, or rule or regulation adopted thereunder, such hospital, health
334 system or hospital-based facility shall be subject to a civil penalty of up
335 to one thousand dollars. The commissioner may issue a notice of
336 violation and civil penalty by first class mail or personal service. Such
337 notice shall include: (i) A reference to the section of the general statutes,
338 rule or section of the regulations of Connecticut state agencies believed
339 or alleged to have been violated; (ii) a short and plain language
340 statement of the matters asserted or charged; (iii) a description of the
341 activity to cease; (iv) a statement of the amount of the civil penalty or
342 penalties that may be imposed; (v) a statement concerning the right to a
343 hearing; and (vi) a statement that such hospital, health system or
344 hospital-based facility may, not later than ten business days after receipt
345 of such notice, make a request for a hearing on the matters asserted.

346 (B) The hospital, health system or hospital-based facility to whom
347 such notice is provided pursuant to subparagraph (A) of this
348 subdivision may, not later than ten business days after receipt of such
349 notice, make written application to the Office of Health Strategy to
350 request a hearing to demonstrate that such violation did not occur. The
351 failure to make a timely request for a hearing shall result in the issuance
352 of a cease and desist order or civil penalty. All hearings held under this
353 subsection shall be conducted in accordance with the provisions of
354 chapter 54.

355 (C) Following any hearing before the Office of Health Strategy
356 pursuant to this subdivision, if said office finds, by a preponderance of
357 the evidence, that such hospital, health system or hospital-based facility
358 violated or is violating any provision of this subsection, any rule or
359 regulation adopted thereunder or any order issued by said office, said
360 office shall issue a final cease and desist order in addition to any civil
361 penalty said office imposes.

362 (6) A violation of this subsection shall be considered an unfair trade
363 practice pursuant to section 42-110b.

364 (m) (1) Each hospital and health system shall report not later than
365 October 1, 2023, and thereafter not later than July 1, 2024, and annually
366 thereafter, to the Commissioner of Health Strategy, on a form prescribed
367 by the commissioner, concerning facility fees charged or billed during
368 the preceding calendar year. Such report shall include, but need not be
369 limited to, (A) the name and address of each facility owned or operated
370 by the hospital or health system that provides services for which a
371 facility fee is charged or billed, and an indication as to whether each
372 facility is located on or outside of the hospital or health system campus,
373 (B) the number of patient visits at each such facility for which a facility
374 fee was charged or billed, (C) the number, total amount and range of
375 allowable facility fees paid at each such facility disaggregated by payer
376 mix, (D) for each facility, the total amount of facility fees charged and
377 the total amount of revenue received by the hospital or health system
378 derived from facility fees, (E) the total amount of facility fees charged
379 and the total amount of revenue received by the hospital or health
380 system from all facilities derived from facility fees, (F) a description of
381 the ten procedures or services that generated the greatest amount of
382 facility fee gross revenue, disaggregated by current procedural
383 terminology (CPT) category **[**(CPT)**]** code for each such procedure or
384 service and, for each such procedure or service, patient volume and the
385 total amount of gross and net revenue received by the hospital or health
386 system derived from facility fees, disaggregated by on-campus and off-
387 campus, and (G) the top ten procedures or services for which facility

388 fees are charged based on patient volume and the gross and net revenue
389 received by the hospital or health system for each such procedure or
390 service, disaggregated by on-campus and off-campus. For purposes of
391 this subsection, "facility" means a hospital-based facility that is located
392 on a hospital campus or outside a hospital campus.

393 (2) The commissioner shall publish the information reported
394 pursuant to subdivision (1) of this subsection, or post a link to such
395 information, on the Internet web site of the Office of Health Strategy.

396 Sec. 4. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

397 (1) "Emergency medical condition" has the same meaning as
398 provided in section 5 of this act;

399 (2) "Emergency medical services" has the same meaning as provided
400 in section 5 of this act;

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

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

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

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

417 with expertise in the relevant field;

418 (7) "Medical hazard" has the same meaning as provided in section 5
419 of this act; and

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

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

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

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

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

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

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

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

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

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

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

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

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

475 (4) A health care entity shall not discharge or discipline a health care
476 provider acting within the scope of such provider's practice, education,

477 training and experience and within the accepted standard of care who
478 refuses to transfer a patient when the health care provider determines,
479 within reasonable medical probability, that the transfer or delay caused
480 by the transfer will create a medical hazard to the patient.

481 Sec. 5. (NEW) (*Effective July 1, 2025*) As used in this section and
482 sections 6 to 13, inclusive, of this act:

483 (1) "Emergency medical services" means (A) medical screening,
484 examination and evaluation by a physician or any other licensed health
485 care provider acting independently or, as required by applicable law,
486 under the supervision of a physician, to determine if an emergency
487 medical condition or active labor exists and, if so, the care, treatment
488 and surgery that is (i) necessary to relieve or eliminate the emergency
489 medical condition, and (ii) within the scope of the facility's license where
490 the physician or provider is practicing, provided such care, treatment or
491 surgery is within the scope of practice of such physician or provider, (B)
492 if it is determined that the emergency medical condition that exists is a
493 pregnancy complication, all reproductive health care services related to
494 the pregnancy complication, including, but not limited to, miscarriage
495 management and the treatment of an ectopic pregnancy, that are (i)
496 necessary to relieve or eliminate the emergency medical condition, and
497 (ii) within the scope of the facility's license where the physician or health
498 care provider is providing such services, provided such services are
499 within the scope of practice of such physician or provider.

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

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

505 (B) Serious impairment to bodily functions; or

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

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

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

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

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

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

517 (6) "Qualified personnel" means a physician or other licensed health
518 care provider acting within the scope of such person's licensure who has
519 the necessary licensure, training, education and experience to provide
520 the emergency medical services necessary to stabilize a patient.

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

536 (8) "Stabilized" means the patient's medical condition is such that,

537 within reasonable medical probability in the opinion of the treating
538 physician or any other qualified personnel acting within the scope of
539 such personnel's licensure either independently or, when required by
540 law, under the supervision of a treating physician, no medical hazard is
541 likely to result from, or occur during, the transfer or discharge of the
542 patient as provided in section 7 or 8 of this act or any other relevant
543 provision of the general statutes.

544 Sec. 6. (NEW) (*Effective July 1, 2025*) (a) Each hospital licensed
545 pursuant to chapter 368v of the general statutes that maintains and
546 operates (1) an emergency department to provide emergency medical
547 services to the public, or (2) a freestanding emergency department, as
548 defined in section 19a-493d of the general statutes, shall provide
549 emergency medical services to any person requesting such services, or
550 for whom such services are requested by an individual with authority
551 to act on behalf of the person, who has a medical condition that places
552 the person in danger of loss of life or serious injury or illness when the
553 hospital has appropriate facilities and qualified personnel available to
554 provide such services.

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

565 (c) A hospital shall render emergency medical services to a person
566 without first questioning such person or any other individual regarding
567 such person's ability to pay for such services. A hospital may follow
568 reasonable registration processes for persons for whom an examination

569 is required under this section, including, but not limited to, inquiring as
570 to whether the person has health insurance and, if so, details regarding
571 such health insurance, provided such inquiry does not delay an
572 evaluation of such person or the provision of emergency medical
573 services to such person. Such reasonable registration processes may not
574 unduly discourage persons from remaining at the hospital for further
575 evaluation.

576 Sec. 7. (NEW) (*Effective July 1, 2025*) (a) A hospital shall not transfer
577 any person needing emergency medical services to another hospital for
578 any nonmedical reason, including, but not limited to, the person's
579 inability to pay for any emergency medical services, unless each of the
580 following conditions are met:

581 (1) A physician has examined and evaluated the person prior to
582 transfer, including, if necessary, by engaging in a consultation. A
583 request for consultation shall be made by the treating physician or by
584 other qualified personnel acting within the scope of such personnel's
585 licensure either independently or, when required by law, under the
586 supervision of a treating physician, provided the request by such
587 qualified personnel is made with the contemporaneous approval of the
588 treating physician.

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

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

601 to treat the person.

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

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

611 (6) The records transferred with the person shall include a transfer
612 summary signed by the transferring physician that contains relevant
613 transfer information available to the transferring hospital at the time of
614 transfer. The form of the transfer summary shall, at a minimum, contain
615 (A) the person's name, address, sex, race, age, insurance status,
616 presenting symptoms and medical condition, (B) the name and business
617 address of the transferring physician or emergency department
618 personnel authorizing the transfer, (C) the declaration of the signor that
619 the signor is assured, within reasonable medical probability, that the
620 transfer creates no medical hazard to the patient, (D) the time and date
621 of the transfer, (E) the reason for the transfer, (F) the time and date the
622 person was first presented at the transferring hospital, and (G) the name
623 of the physician at the receiving hospital consenting to the transfer and
624 the time and date of the consent. Neither the transferring physician nor
625 the transferring hospital shall be required to duplicate, in the transfer
626 summary, information contained in medical records transferred with
627 the person.

628 (7) The hospital shall ask the patient if the patient has a preferred
629 contact person to be notified about the transfer and, prior to the transfer,
630 the hospital shall make a reasonable attempt to contact such person and
631 alert them about the proposed transfer. If the patient is not able to
632 respond, the hospital shall make a reasonable effort to ascertain the

633 identity of the preferred contact person or the next of kin and alert such
634 person about the transfer. The hospital shall document in the patient's
635 medical record any attempt to contact a preferred contact person or next
636 of kin.

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

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

645 Sec. 8. (NEW) (*Effective July 1, 2025*) (a) A receiving hospital shall
646 accept the transfer of a person from a transferring hospital to the extent
647 required pursuant to section 7 of this act or any contract obligation the
648 receiving hospital has to care for the person.

649 (b) The receiving hospital shall provide personnel and equipment
650 reasonably required by the applicable standard of practice and the
651 regulations adopted pursuant to section 7 of this act to care for the
652 transferred patient.

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

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

662 Sec. 9. (NEW) (*Effective July 1, 2025*) (a) The Commissioner of Public

663 Health shall require as a condition of licensure of a hospital, pursuant
664 to section 19a-491 of the general statutes, that each hospital adopt, in
665 collaboration with the medical staff of the hospital, policies and transfer
666 protocols consistent with sections 4 to 13, inclusive, of this act and the
667 regulations adopted pursuant to section 7 of this act.

668 (b) The commissioner shall require as a condition of licensure of a
669 hospital, pursuant to section 19a-491 of the general statutes, that each
670 hospital communicate, both orally and in writing, to each person who
671 presents to the hospital's emergency department, or such person's
672 authorized representative, if any such representative is present and the
673 person is unable to understand verbal or written communication, of the
674 reasons for the transfer or refusal to provide emergency medical services
675 and of the person's right to receive such services to stabilize an
676 emergency medical condition prior to transfer to another hospital or
677 health care facility or discharge without regard to ability to pay.
678 Nothing in this subsection shall be construed to require notification of
679 the reasons for the transfer in advance of the transfer when (1) a person
680 is unaccompanied, (2) the hospital has made a reasonable effort to locate
681 an authorized representative of the person, and (3) due to the person's
682 physical or mental condition, notification is not possible. Each hospital
683 shall prominently post a sign in its emergency department informing
684 the public of their rights under sections 4 to 13, inclusive, of this act.
685 Both the written communication and sign required under this
686 subsection shall include the contact information for the Department of
687 Public Health and identify the department as the state agency to contact
688 if a person wishes to complain about the hospital's conduct.

689 (c) Not later than thirty days after the adoption of regulations
690 pursuant to section 7 of this act, each hospital shall submit its policies
691 and protocols adopted pursuant to subsection (a) of this section to the
692 Department of Public Health. Each hospital shall submit any revisions
693 to such policies or protocols to the department not later than thirty days
694 prior to the effective date of such revisions.

695 Sec. 10. (NEW) (*Effective July 1, 2025*) (a) Each hospital shall maintain
696 records of each transfer of a person made or received, including the
697 transfer summary described in subdivision (6) of subsection (a) of
698 section 7 of this act, for a period of not less than three years following
699 the date of the transfer.

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

706 (c) Each receiving hospital, physician and licensed emergency room
707 health care personnel at the receiving hospital, and each licensed
708 emergency medical services personnel, as defined in section 19a-175 of
709 the general statutes, effectuating the transfer of a person who knows of
710 an apparent violation of any provision of sections 5 to 12, inclusive, of
711 this act or the regulations adopted pursuant to section 7 of this act, shall,
712 and each transferring hospital and each physician and other provider
713 involved in the transfer at such hospital may, report such violation to
714 the Department of Public Health, in a form and manner prescribed by
715 the Commissioner of Public Health, not later than fourteen days after
716 the occurrence of such violation. When two or more persons required to
717 report a violation have joint knowledge of an apparent violation, a
718 single report may be made by a member of the hospital personnel
719 selected by mutual agreement in accordance with hospital protocols.
720 Any person required to report a violation who disagrees with a
721 proposed joint report shall report individually.

722 (d) No hospital, state agency or person shall retaliate against,
723 penalize, institute a civil action against or recover monetary relief from,
724 or otherwise cause any injury to, any physician, other hospital personnel
725 or emergency medical services personnel for reporting in good faith an
726 apparent violation of any provision of sections 5 to 12, inclusive, of this

727 act or the regulations adopted pursuant to section 7 of this act to the
728 Department of Public Health, the hospital, a member of the hospital's
729 medical staff or any other interested party or government agency.

730 Sec. 11. (NEW) (*Effective July 1, 2025*) (a) Except as otherwise provided
731 in sections 5 to 12, inclusive, of this act, the Commissioner of Public
732 Health shall investigate each alleged violation of said sections and the
733 regulations adopted pursuant to section 7 of this act unless the
734 commissioner concludes that the allegation does not include facts
735 requiring further investigation or is otherwise unmeritorious.

736 (b) The Commissioner of Public Health may take any action
737 authorized by sections 19a-494 and 19a-494a of the general statutes
738 against a hospital or authorized by section 19a-17 of the general statutes
739 against a licensed health care provider for a violation of any provision
740 of sections 5 to 12, inclusive, of this act.

741 Sec. 12. (NEW) (*Effective July 1, 2025*) (a) A hospital shall not base the
742 provision of emergency medical services to a person, in whole or in part,
743 upon, or discriminate against a person based upon, the person's
744 ethnicity, citizenship, age, preexisting medical condition, insurance
745 status, economic status, ability to pay for medical services, sex, race,
746 color, religion, disability, genetic information, marital status, sexual
747 orientation, primary language or immigration status, except to the
748 extent that a circumstance such as age, sex, pregnancy, medical
749 condition related to childbirth, preexisting medical condition or
750 physical or mental disability is medically significant to the provision of
751 appropriate medical care to the patient. Each hospital shall adopt a
752 policy to implement the provisions of this section.

753 (b) Unless otherwise permitted by contract, each hospital shall
754 prohibit each physician who serves on an on-call basis in the hospital's
755 emergency department from refusing to respond to a call on the basis of
756 the person's ethnicity, citizenship, age, preexisting medical condition,
757 insurance status, economic status, ability to pay for medical services,
758 sex, race, color, religion, disability, current medical condition, genetic

759 information, marital status, sexual orientation, primary language or
760 immigration status, except to the extent that a circumstance such as age,
761 sex, preexisting medical condition or physical or mental disability is
762 medically significant to the provision of appropriate medical care to the
763 patient. If a contract that was in existence on or before July 1, 2025,
764 between a physician and hospital for the provision of emergency
765 department coverage prevents a hospital from imposing the prohibition
766 required under this subsection, the contract shall be revised to include
767 such prohibition as soon as it is legally permissible to make such a
768 revision. Nothing in this section shall be construed to require any
769 physician to serve on an on-call basis for a hospital.

770 Sec. 13. (NEW) (*Effective July 1, 2025*) (a) Any individual harmed by a
771 violation of any provision of sections 4 to 12, inclusive, of this act may
772 bring, not later than one hundred eighty days after the occurrence of
773 such violation, a civil action against a hospital or other health care entity
774 for such violation.

775 (b) Any hospital or other health care entity found to have violated
776 any provision of sections 4 to 12, inclusive, of this act shall be liable for
777 compensatory damages, with costs and such reasonable attorney's fees
778 as may be allowed by the court. In the case of a health care provider who
779 has been subjected to retaliation or other disciplinary action in violation
780 of any provision of sections 4 to 12, inclusive, of this act, the hospital or
781 other health care entity shall also be liable for the full amount of gross
782 loss of wages in addition to any compensatory damages for which the
783 hospital or health care entity is liable under this subsection.

784 (c) The court may also provide injunctive relief to prevent further
785 violations of any provision of sections 4 to 12, inclusive, of this act.

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

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

794 Sec. 14. (*Effective from passage*) The Health Care Cabinet established
795 pursuant to section 19a-725 of the general statutes shall study the
796 feasibility of regulating stop loss policies used in conjunction with
797 health plans as fully insured health plans. The cabinet shall hold one or
798 more informational hearings as part of such study. Not later than
799 January 1, 2026, the Commissioner of Health Strategy shall report, in
800 accordance with the provisions of section 11-4a of the general statutes,
801 to the joint standing committees of the General Assembly having
802 cognizance of matters relating to insurance and public health regarding
803 the results of such study.

804 Sec. 15. Section 19a-639 of the general statutes is repealed and the
805 following is substituted in lieu thereof (*Effective July 1, 2025*):

806 (a) In any deliberations involving a certificate of need application
807 filed pursuant to section 19a-638, the unit shall take into consideration
808 and make written findings concerning each of the following guidelines
809 and principles:

810 (1) Whether the proposed project is consistent with any applicable
811 policies and standards adopted in regulations by the Office of Health
812 Strategy;

813 (2) The relationship of the proposed project to the state-wide health
814 care facilities and services plan;

815 (3) Whether there is a clear public need for the health care facility or
816 services proposed by the applicant;

817 (4) Whether the applicant has satisfactorily demonstrated how the
818 proposal will impact the financial strength of the health care system in
819 the state or that the proposal is financially feasible for the applicant;

820 (5) Whether the applicant has satisfactorily demonstrated how the
821 proposal will improve quality, accessibility and cost effectiveness of
822 health care delivery in the region, including, but not limited to,
823 provision of or any change in the access to services for Medicaid
824 recipients and indigent persons;

825 (6) The applicant's past and proposed provision of health care
826 services to relevant patient populations and payer mix, including, but
827 not limited to, access to services by Medicaid recipients and indigent
828 persons;

829 (7) Whether the applicant has satisfactorily identified the population
830 to be served by the proposed project and satisfactorily demonstrated
831 that the identified population has a need for the proposed services;

832 (8) The utilization of existing health care facilities and health care
833 services in the service area of the applicant;

834 (9) Whether the applicant has satisfactorily demonstrated that the
835 proposed project shall not result in an unnecessary duplication of
836 existing or approved health care services or facilities;

837 (10) Whether an applicant, who has failed to provide or reduced
838 access to services by Medicaid recipients or indigent persons, has
839 demonstrated good cause for doing so, which shall not be demonstrated
840 solely on the basis of differences in reimbursement rates between
841 Medicaid and other health care payers;

842 (11) Whether the applicant has satisfactorily demonstrated that the
843 proposal will not negatively impact the diversity of health care
844 providers and patient choice in the geographic region; and

845 (12) Whether the applicant has satisfactorily demonstrated that any
846 consolidation resulting from the proposal will not adversely affect
847 health care costs or accessibility to care.

848 **[**(b) In deliberations as described in subsection (a) of this section,

849 there shall be a presumption in favor of approving the certificate of need
850 application for a transfer of ownership of a large group practice, as
851 described in subdivision (3) of subsection (a) of section 19a-638, when
852 an offer was made in response to a request for proposal or similar
853 voluntary offer for sale.]

854 [(c)] (b) The unit, as it deems necessary, may revise or supplement the
855 guidelines and principles, set forth in subsection (a) of this section,
856 through regulation.

857 [(d)] (c) (1) For purposes of this subsection and subsection [(e)] (d) of
858 this section:

859 (A) "Affected community" means a municipality where a hospital is
860 physically located or a municipality whose inhabitants are regularly
861 served by a hospital;

862 (B) "Hospital" has the same meaning as provided in section 19a-490;

863 (C) "New hospital" means a hospital as it exists after the approval of
864 an agreement pursuant to section 19a-486b, as amended by this act, or a
865 certificate of need application for a transfer of ownership of a hospital;

866 (D) "Purchaser" means a person who is acquiring, or has acquired,
867 any assets of a hospital through a transfer of ownership of a hospital;

868 (E) "Transacting party" means a purchaser and any person who is a
869 party to a proposed agreement for transfer of ownership of a hospital;

870 (F) "Transfer" means to sell, transfer, lease, exchange, option, convey,
871 give or otherwise dispose of or transfer control over, including, but not
872 limited to, transfer by way of merger or joint venture not in the ordinary
873 course of business; and

874 (G) "Transfer of ownership of a hospital" means a transfer that
875 impacts or changes the governance or controlling body of a hospital,
876 including, but not limited to, all affiliations, mergers or any sale or

877 transfer of net assets of a hospital and for which a certificate of need
878 application or a certificate of need determination letter is filed on or after
879 December 1, 2015.

880 (2) In any deliberations involving a certificate of need application
881 filed pursuant to section 19a-638 that involves the transfer of ownership
882 of a hospital, the unit shall, in addition to the guidelines and principles
883 set forth in subsection (a) of this section and those prescribed through
884 regulation pursuant to subsection **[**(c)**]** (b) of this section, take into
885 consideration and make written findings concerning each of the
886 following guidelines and principles:

887 (A) Whether the applicant fairly considered alternative proposals or
888 offers in light of the purpose of maintaining health care provider
889 diversity and consumer choice in the health care market and access to
890 affordable quality health care for the affected community; and

891 (B) Whether the plan submitted pursuant to section 19a-639a
892 demonstrates, in a manner consistent with this chapter, how health care
893 services will be provided by the new hospital for the first three years
894 following the transfer of ownership of the hospital, including any
895 consolidation, reduction, elimination or expansion of existing services
896 or introduction of new services.

897 (3) The unit shall deny any certificate of need application involving a
898 transfer of ownership of a hospital unless the commissioner finds that
899 the affected community will be assured of continued access to high
900 quality and affordable health care after accounting for any proposed
901 change impacting hospital staffing.

902 (4) The unit may deny any certificate of need application involving a
903 transfer of ownership of a hospital subject to a cost and market impact
904 review pursuant to section 19a-639f, as amended by this act, if the
905 commissioner finds that (A) the affected community will not be assured
906 of continued access to high quality and affordable health care after
907 accounting for any consolidation in the hospital and health care market

908 that may lessen health care provider diversity, consumer choice and
909 access to care, and (B) any likely increases in the prices for health care
910 services or total health care spending in the state may negatively impact
911 the affordability of care.

912 (5) The unit may place any conditions on the approval of a certificate
913 of need application involving a transfer of ownership of a hospital
914 consistent with the provisions of this chapter. Before placing any such
915 conditions, the unit shall weigh the value of such conditions in
916 promoting the purposes of this chapter against the individual and
917 cumulative burden of such conditions on the transacting parties and the
918 new hospital. For each condition imposed, the unit shall include a
919 concise statement of the legal and factual basis for such condition and
920 the provision or provisions of this chapter that it is intended to promote.
921 Each condition shall be reasonably tailored in time and scope. The
922 transacting parties or the new hospital shall have the right to make a
923 request to the unit for an amendment to, or relief from, any condition
924 based on changed circumstances, hardship or for other good cause.

925 **[**(e)**]** (d) (1) If the certificate of need application (A) involves the
926 transfer of ownership of a hospital, (B) the purchaser is a hospital, as
927 defined in section 19a-490, whether located within or outside the state,
928 that had net patient revenue for fiscal year 2013 in an amount greater
929 than one billion five hundred million dollars or a hospital system, as
930 defined in section 19a-486i, whether located within or outside the state,
931 that had net patient revenue for fiscal year 2013 in an amount greater
932 than one billion five hundred million dollars, or any person that is
933 organized or operated for profit, and (C) such application is approved,
934 the unit shall hire an independent consultant to serve as a post-transfer
935 compliance reporter for a period of three years after completion of the
936 transfer of ownership of the hospital. Such reporter shall, at a minimum:
937 (i) Meet with representatives of the purchaser, the new hospital and
938 members of the affected community served by the new hospital not less
939 than quarterly; and (ii) report to the unit not less than quarterly
940 concerning (I) efforts the purchaser and representatives of the new

941 hospital have taken to comply with any conditions the unit placed on
942 the approval of the certificate of need application and plans for future
943 compliance, and (II) community benefits and uncompensated care
944 provided by the new hospital. The purchaser shall give the reporter
945 access to its records and facilities for the purposes of carrying out the
946 reporter's duties. The purchaser shall hold a public hearing in the
947 municipality in which the new hospital is located not less than annually
948 during the reporting period to provide for public review and comment
949 on the reporter's reports and findings.

950 (2) If the reporter finds that the purchaser has breached a condition
951 of the approval of the certificate of need application, the unit may, in
952 consultation with the purchaser, the reporter and any other interested
953 parties it deems appropriate, implement a performance improvement
954 plan designed to remedy the conditions identified by the reporter and
955 continue the reporting period for up to one year following a
956 determination by the unit that such conditions have been resolved.

957 (3) The purchaser shall provide funds, in an amount determined by
958 the unit not to exceed two hundred thousand dollars annually, for the
959 hiring of the post-transfer compliance reporter.

960 **[**(f)**]** (e) Nothing in subsection **[**(d)**]** (c) or **[**(e)**]** (d) of this section shall
961 apply to a transfer of ownership of a hospital in which either a certificate
962 of need application is filed on or before December 1, 2015, or where a
963 certificate of need determination letter is filed on or before December 1,
964 2015.

965 Sec. 16. Subsection (b) of section 19a-486b of the general statutes is
966 repealed and the following is substituted in lieu thereof (*Effective July 1,*
967 *2025*):

968 (b) The commissioner and the Attorney General may place any
969 conditions on the approval of an application that relate to the purposes
970 of sections 19a-486a to 19a-486h, inclusive. In placing any such
971 conditions the commissioner shall follow the guidelines and criteria

972 described in subdivision (4) of subsection **[**(d)**]** (c) of section 19a-639, as
973 amended by this act. Any such conditions may be in addition to any
974 conditions placed by the commissioner pursuant to subdivision (4) of
975 subsection **[**(d)**]** (c) of section 19a-639, as amended by this act.

976 Sec. 17. Subsection (d) of section 19a-639f of the general statutes is
977 repealed and the following is substituted in lieu thereof (*Effective July 1,*
978 *2025*):

979 (d) The cost and market impact review conducted pursuant to this
980 section shall examine factors relating to the businesses and relative
981 market positions of the transacting parties as defined in subsection **[**(d)**]**
982 (c) of section 19a-639, as amended by this act, and may include, but need
983 not be limited to: (1) The transacting parties' size and market share
984 within its primary service area, by major service category and within its
985 dispersed service areas; (2) the transacting parties' prices for services,
986 including the transacting parties' relative prices compared to other
987 health care providers for the same services in the same market; (3) the
988 transacting parties' health status adjusted total medical expense,
989 including the transacting parties' health status adjusted total medical
990 expense compared to that of similar health care providers; (4) the quality
991 of the services provided by the transacting parties, including patient
992 experience; (5) the transacting parties' cost and cost trends in
993 comparison to total health care expenditures state wide; (6) the
994 availability and accessibility of services similar to those provided by
995 each transacting party, or proposed to be provided as a result of the
996 transfer of ownership of a hospital within each transacting party's
997 primary service areas and dispersed service areas; (7) the impact of the
998 proposed transfer of ownership of the hospital on competing options for
999 the delivery of health care services within each transacting party's
1000 primary service area and dispersed service area including the impact on
1001 existing service providers; (8) the methods used by the transacting
1002 parties to attract patient volume and to recruit or acquire health care
1003 professionals or facilities; (9) the role of each transacting party in serving
1004 at-risk, underserved and government payer patient populations,

1005 including those with behavioral, substance use disorder and mental
1006 health conditions, within each transacting party's primary service area
1007 and dispersed service area; (10) the role of each transacting party in
1008 providing low margin or negative margin services within each
1009 transacting party's primary service area and dispersed service area; (11)
1010 consumer concerns, including, but not limited to, complaints or other
1011 allegations that a transacting party has engaged in any unfair method of
1012 competition or any unfair or deceptive act or practice; and (12) any other
1013 factors that the unit determines to be in the public interest.

1014 Sec. 18. Subsection (j) of section 19a-639f of the general statutes is
1015 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1016 *2025*):

1017 (j) The unit shall retain an independent consultant with expertise on
1018 the economic analysis of the health care market and health care costs
1019 and prices to conduct each cost and market impact review, as described
1020 in this section. The unit shall submit bills for such services to the
1021 purchaser, as defined in subsection **[**(d)**]** <u>(c)</u> of section 19a-639<u>, as</u>
1022 <u>amended by this act</u>. Such purchaser shall pay such bills not later than
1023 thirty days after receipt. Such bills shall not exceed two hundred
1024 thousand dollars per application. The provisions of chapter 57, sections
1025 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any
1026 agreement executed pursuant to this subsection.

1027 Sec. 19. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

1028 (1) "Collateral costs" means any out-of-pocket costs, other than the
1029 cost of the procedure itself, necessary to receive reproductive health care
1030 services in the state, including, but not limited to, costs for travel,
1031 lodging and meals;

1032 (2) "Gender-affirming health care services" has the same meaning as
1033 provided in section 52-571n of the general statutes;

1034 (3) "Health care provider" means any person licensed under the

1035 provisions of federal or state law to provide health care services;

1036 (4) "Nonprofit organization" means an organization that is exempt
1037 from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code
1038 of 1986, or any subsequent corresponding internal revenue code of the
1039 United States, as amended from time to time;

1040 (5) "Patient-identifiable data" means any information that identifies,
1041 or may reasonably be used as a basis to identify, an individual patient;

1042 (6) "Qualified person" means a person who is a resident of a state that
1043 has enacted laws that limit such person's access to reproductive health
1044 care services or gender-affirming health care services; and

1045 (7) "Reproductive health care services" means all medical, surgical,
1046 counseling or referral services relating to the human reproductive
1047 system, including, but not limited to, services relating to fertility,
1048 pregnancy, contraception and abortion.

1049 (b) There is established an account to be known as the "safe harbor
1050 account", which shall be a separate, nonlapsing account of the State
1051 Treasurer. The account shall contain any moneys required by law to be
1052 deposited in the account and any funds received from any public or
1053 private contributions, gifts, grants, donations, bequests or devises to the
1054 account. Moneys in the account shall be expended by the board of
1055 trustees, established pursuant to subsection (c) of this section, for the
1056 purposes of providing grants to (1) health care providers who provide
1057 reproductive health care services or gender-affirming health care
1058 services, (2) nonprofit organizations whose mission includes providing
1059 funding for reproductive health care services or the collateral costs
1060 incurred by qualified persons to receive such services in the state, or (3)
1061 nonprofit organizations that serve LGBTQ+ youth or families in the
1062 state for the purpose of reimbursing or paying for collateral costs
1063 incurred by qualified persons to receive reproductive health care
1064 services or gender-affirming health care services.

1065 (c) The safe harbor account shall be administered by a board of
1066 trustees consisting of the following members:

1067 (1) The Treasurer, or the Treasurer's designee, who shall serve as
1068 chairperson of the board of trustees;

1069 (2) The Commissioner of Mental Health and Addiction Services, or
1070 the commissioner's designee;

1071 (3) The Commissioner of Social Services, or the commissioner's
1072 designee;

1073 (4) The Commissioner of Public Health, or the commissioner's
1074 designee; and

1075 (5) Five members appointed by the Treasurer, (A) one of whom shall
1076 be a provider of reproductive health care services in the state, (B) one of
1077 whom shall have experience working with members of the LGBTQ+
1078 community, and (C) one of whom shall have experience working with
1079 providers of reproductive health care services. When making such
1080 appointments, the Treasurer shall use the Treasurer's best efforts to
1081 ensure that the board of trustees reflects the racial, gender and
1082 geographic diversity of the state.

1083 (d) Not later than September 1, 2025, the board of trustees shall adopt
1084 policies and procedures concerning the awarding of grants pursuant to
1085 the provisions of this section. Such policies and procedures shall
1086 include, but need not be limited to, (1) grant application procedures, (2)
1087 eligibility criteria for applicants, (3) eligibility criteria for collateral costs,
1088 (4) consideration of need, including, but not limited to, financial need,
1089 of the applicant, and (5) procedures to coordinate with any national
1090 network created to perform similar functions to those of the safe harbor
1091 account, including, but not limited to, procedures for the acceptance of
1092 funding transferred to the safe harbor account for a particular use. Such
1093 policies and procedures shall not require the collection or retention of
1094 patient-identifiable data in order to receive a grant. Such policies and

1095 procedures may be updated as deemed necessary by the board of
1096 trustees. In the event that the board of trustees determines that the
1097 policies and procedures adopted pursuant to the provisions of this
1098 subsection are inadequate with respect to (A) determining the eligibility
1099 of a certain health care provider or nonprofit organization for a grant,
1100 or (B) whether a certain health care service received by a qualified
1101 person or collateral cost incurred by a qualified person is eligible to be
1102 reimbursed or paid by a health care provider or nonprofit organization
1103 using grant moneys received pursuant to this section, the board of
1104 trustees may make a fact-based determination as to such eligibility.

1105 Sec. 20. (NEW) (*Effective from passage*) It is hereby declared that opioid
1106 use disorder constitutes a public health crisis in this state and will
1107 continue to constitute a public health crisis until each goal reported by
1108 the Connecticut Alcohol and Drug Policy Council pursuant to
1109 subsection (f) of section 17a-667a of the general statutes, as amended by
1110 this act, is attained.

1111 Sec. 21. Section 17a-667a of the general statutes is amended by adding
1112 subsection (f) as follows (*Effective from passage*):

1113 (NEW) (f) The Connecticut Alcohol and Drug Policy Council shall
1114 convene a working group to establish one or more goals for the state to
1115 achieve in its efforts to combat the prevalence opioid use disorder in the
1116 state. Not later than January 1, 2026, the council shall report, in
1117 accordance with the provisions of section 11-4a, to the joint standing
1118 committee of the General Assembly having cognizance of matters
1119 relating to public health regarding each goal established by the working
1120 group.

1121 Sec. 22. (*Effective from passage*) (a) As used in this section:

1122 (1) "Priority school district" has the same meaning as described in
1123 section 10-266p of the general statutes; and

1124 (2) "Geofence" means any technology that uses global positioning

1125 coordinates, cell tower connectivity, cellular data, radio frequency
1126 identification, wireless fidelity technology data or any other form of
1127 location detection, or any combination of such coordinates, connectivity,
1128 data, identification or other form of location detection, to establish a
1129 virtual boundary.

1130 (b) Not later than January 1, 2026, the Department of Education, in
1131 collaboration with the Department of Mental Health and Addiction
1132 Services, shall establish a mental and behavioral health awareness and
1133 treatment pilot program in priority school districts. The program shall
1134 enable not less than one hundred thousand students in such districts to
1135 utilize an electronic mental and behavioral health awareness and
1136 treatment tool through an Internet web site, online service or mobile
1137 application, which tool shall be selected by the Commissioners of
1138 Education and Mental Health and Addiction Services and provide each
1139 of the following:

1140 (1) Mental and behavioral health education resources to promote
1141 awareness and understanding of mental and behavioral health issues;

1142 (2) Peer-to-peer support services, including, but not limited to, a
1143 moderated online peer chat room, where comments submitted by
1144 students for posting in the chat room are prescreened and filtered
1145 through by a moderator prior to posting, to encourage social connection
1146 and mutual support among students; and

1147 (3) Private online sessions with mental or behavioral health care
1148 providers licensed in the state who (A) have demonstrated experience
1149 delivering mental or behavioral health care services to school districts
1150 serving both rural and urban student populations, and (B) shall be
1151 selected or approved by the Commissioner of Mental Health and
1152 Addiction Services, provided such sessions comply with the provisions
1153 of section 19a-906 of the general statutes concerning telehealth and the
1154 provisions of section 19a-14c of the general statutes concerning the
1155 provision of outpatient mental health treatment to minors.

1156 (c) (1) During its first year of operation, the pilot program shall have
1157 the following objectives: (A) To build partnerships between priority
1158 school districts and community organizations providing mental and
1159 behavioral health care services; and (B) to launch a digital marketing
1160 campaign using tools, including, but not limited to, a geofence, to raise
1161 awareness and engagement among students concerning mental and
1162 behavioral health issues affecting students.

1163 (2) Not later than January 1, 2026, the Commissioners of Education
1164 and Mental Health and Addiction Services shall jointly report, in
1165 accordance with the provisions of section 11-4a of the general statutes,
1166 regarding the program's success in achieving such objectives to the joint
1167 standing committees of the General Assembly having cognizance of
1168 matters relating to public health and education.

1169 (d) (1) During its second year of operation, the pilot program shall
1170 have the following objectives: (A) To refer students to mental and
1171 behavioral health care providers, as needed; and (B) to enhance
1172 students' engagement with mental and behavioral health tools,
1173 including, but not limited to, coping strategies and clinician support.

1174 (2) Not later than January 1, 2027, the Commissioners of Education
1175 and Mental Health and Addiction Services shall jointly report, in
1176 accordance with the provisions of section 11-4a of the general statutes,
1177 regarding the program's success in achieving such objectives to the joint
1178 standing committees of the General Assembly having cognizance of
1179 matters relating to public health and education.

1180 Sec. 23. (*Effective from passage*) The sum of three million six hundred
1181 thousand dollars is appropriated to the Department of Education from
1182 the General Fund, for the fiscal year ending June 30, 2026, for the
1183 administration of the mental and behavioral health awareness and
1184 treatment pilot program established pursuant to section 22 of this act.

1185 Sec. 24. (NEW) (*Effective from passage*) There is established an account
1186 to be known as the "public health urgent communication account",

1187 which shall be a separate, nonlapsing account. The account shall contain
1188 any moneys required by law to be deposited in the account. Moneys in
1189 the account shall be expended by the Department of Public Health for
1190 the purposes of providing timely, effective communication to members
1191 of the general public, health care providers and other relevant
1192 stakeholders during a public health emergency, as described in section
1193 19a-131a of the general statutes.

1194 Sec. 25. (*Effective from passage*) The sum of five million dollars is
1195 appropriated to the Department of Public Health from the General
1196 Fund, for the fiscal year ending June 30, 2026, for deposit into the "public
1197 health urgent communication account" established pursuant to section
1198 24 of this act.

1199 Sec. 26. (NEW) (*Effective from passage*) There is established an account
1200 to be known as the "emergency public health financial safeguard
1201 account", which shall be a separate, nonlapsing account. The account
1202 shall contain any moneys required by law to be deposited in the account.
1203 Moneys in the account shall be expended by the Department of Public
1204 Health for the purposes of addressing unexpected shortfalls in public
1205 health funding and ensuring the Department of Public Health's ability
1206 to respond to the health care needs of state residents and provide a
1207 continuity of essential public health services.

1208 Sec. 27. (*Effective from passage*) The sum of thirty million dollars is
1209 appropriated to the Department of Public Health from the General
1210 Fund, for the fiscal year ending June 30, 2026, for deposit into the
1211 "emergency public health financial safeguard account" established
1212 pursuant to section 26 of this act.

1213 Sec. 28. (NEW) (*Effective October 1, 2025*) (a) As used in this section
1214 and sections 29 to 31, inclusive, of this act:

1215 (1) "Commissioner" means the Commissioner of Public Health;

1216 (2) "Department" means the Department of Public Health;

1217 (3) "Health care administrator" means a person employed by a
1218 hospital who is a:

1219 (A) Nonclinical hospital manager with direct supervisory authority
1220 over clinical health care providers who is responsible for one or more of
1221 the following activities:

1222 (i) Hiring, scheduling, evaluating and providing direct supervision
1223 of clinical health care providers;

1224 (ii) Monitoring hospital activities for compliance with state or federal
1225 regulatory requirements; or

1226 (iii) Developing fiscal reports for clinical units of the hospital or the
1227 hospital as a whole; or

1228 (B) Nonclinical hospital director, officer or executive who has direct
1229 or indirect supervisory authority over only nonclinical hospital
1230 managers described in subparagraph (A) of this subdivision, for one or
1231 more of the following activities:

1232 (i) Hiring and supervising such nonclinical hospital managers;

1233 (ii) Providing oversight of operations for the hospital or any of its
1234 departments;

1235 (iii) Developing policies and procedures establishing the standards of
1236 patient care;

1237 (iv) Providing oversight of budgetary and financial decisions related
1238 to operations and the delivery of patient care for the hospital or any of
1239 its departments; and

1240 (v) Ensuring that hospital policies comply with state and federal
1241 regulatory requirements; and

1242 (4) "Hospital" means an institution licensed as a hospital pursuant to
1243 chapter 368v of the general statutes.

1244 Sec. 29. (NEW) (*Effective October 1, 2025*) (a) No person shall practice
1245 as a health care administrator unless such person is licensed pursuant
1246 to section 30 of this act.

1247 (b) No person may use the title "health care administrator" or make
1248 use of any title, words, letters or abbreviations indicating or implying
1249 that such person is licensed to practice as a health care administrator
1250 pursuant to section 30 of this act.

1251 Sec. 30. (NEW) (*Effective October 1, 2025*) (a) Except as provided in
1252 subsection (b) of this section, the commissioner shall grant a license to
1253 practice as a health care administrator to an applicant who presents
1254 evidence satisfactory to the commissioner that such applicant has: (1) A
1255 baccalaureate or graduate degree in health care administration, public
1256 health or a related field from a regionally accredited institution of higher
1257 education, or from an institution of higher education outside of the
1258 United States that is legally chartered to grant postsecondary degrees in
1259 the country in which such institution is located; (2) passed an
1260 examination prescribed by the department designed to test the
1261 applicant's knowledge of health care laws, patient safety protocols and
1262 health-related ethical guidelines; and (3) submitted a completed
1263 application in a form and manner prescribed by the department. The fee
1264 for an initial license under this section shall be two hundred dollars.

1265 (b) The department may grant licensure without examination, subject
1266 to payment of fees with respect to the initial application, to any
1267 applicant who is currently licensed or certified as a health care
1268 administrator in another state, territory or commonwealth of the United
1269 States, provided such state, territory or commonwealth maintains
1270 licensure or certification standards that, in the opinion of the
1271 department, are equivalent to or higher than the standards of this state.
1272 No license shall be issued under this section to any applicant against
1273 whom professional disciplinary action is pending or who is the subject
1274 of an unresolved complaint.

1275 (c) A license issued to a health care administrator under this section

1276 may be renewed annually in accordance with the provisions of section
1277 19a-88 of the general statutes, as amended by this act. The fee for such
1278 renewal shall be one hundred five dollars. Each licensed health care
1279 administrator applying for license renewal shall furnish evidence
1280 satisfactory to the commissioner of having participated in continuing
1281 education programs prescribed by the department. The commissioner
1282 shall adopt regulations, in accordance with chapter 54 of the general
1283 statutes, to (1) define basic requirements for continuing education
1284 programs, (2) delineate qualifying programs, (3) establish a system of
1285 control and reporting, and (4) provide for waiver of the continuing
1286 education requirement for good cause.

1287 Sec. 31. (NEW) (*Effective October 1, 2025*) (a) The department shall
1288 have jurisdiction to hear all charges of unacceptable conduct brought
1289 against a person licensed to practice as a health care administrator. The
1290 commissioner shall provide written notice of such hearing to such
1291 person not later than thirty days prior to such hearing. After holding
1292 such hearing, the department may take any of the actions set forth in
1293 section 19a-17 of the general statutes, if it finds that any grounds for
1294 action by the department enumerated in subsection (b) of this section
1295 exist. Any person aggrieved by the finding of the department may
1296 appeal such finding in accordance with the provisions of section 4-183
1297 of the general statutes, and such appeal shall have precedence over
1298 nonprivileged cases in respect to order of trial.

1299 (b) The department may take action under section 19a-17 for any of
1300 the following reasons: (1) A fiscal or operational decision that results in
1301 injury to a patient or creates an unreasonable risk that a patient may be
1302 harmed; (2) a violation by a licensed health care provider of a state or
1303 federal statute or administrative rule regulating a profession when the
1304 health care administrator was responsible for the oversight of the
1305 licensed health care provider; (3) aiding or abetting a licensed health
1306 care provider to practice the provider's health care profession after a
1307 patient complaint or adverse event has been reported to the hospital
1308 employing the licensed health care administrator, the department or the

1309 appropriate disciplining authority, while the complaint or adverse
1310 event is being investigated, and if harm, disability or death of a patient
1311 occurred after the complaint or report of the adverse event; (4) failure to
1312 adequately supervise licensed clinical staff and nonclinical staff to the
1313 extent that a patient's health or safety is at risk; (5) any administrative,
1314 operational or fiscal decision that impedes a clinical licensed health care
1315 provider from adhering to standards of practice or leads to patient
1316 harm, disability or death; or (6) a fiscal or operational decision resulting
1317 in the inability of licensed clinical health care providers to practice with
1318 reasonable skill and safety, regardless of the occurrence of patient harm,
1319 disability or death. The commissioner may order a license holder to
1320 submit to a reasonable physical or mental examination if such license
1321 holder's physical or mental capacity to practice safely is being
1322 investigated. The commissioner may petition the superior court for the
1323 judicial district of Hartford to enforce such order or any action taken
1324 pursuant to section 19a-17.

1325 Sec. 32. Subdivision (1) of subsection (e) of section 19a-88 of the
1326 general statutes is repealed and the following is substituted in lieu
1327 thereof (*Effective October 1, 2025*):

1328 (e) (1) Each person holding a license or certificate issued under
1329 <u>section 30 of this act,</u> section 19a-514, 20-65k, 20-74s, 20-185k, 20-185*l*, 20-
1330 195cc or 20-206*ll* and chapters 370 to 373, inclusive, 375, 378 to 381a,
1331 inclusive, 383 to 383c, inclusive, 383g, 384, 384a, 384b, 385, 393a, 395, 399
1332 or 400a and section 20-206n or 20-206o shall, annually, or, in the case of
1333 a person holding a license as a marital and family therapist associate
1334 under section 20-195c on or before twenty-four months after the date of
1335 initial licensure, during the month of such person's birth, apply for
1336 renewal of such license or certificate to the Department of Public Health,
1337 giving such person's name in full, such person's residence and business
1338 address and such other information as the department requests.

1339 Sec. 33. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

1340 (1) "Advanced practice registered nurse" means an individual

1341 licensed as an advanced practice registered nurse pursuant to chapter
1342 378 of the general statutes;

1343 (2) "Physician" means an individual licensed as a physician pursuant
1344 to chapter 370 of the general statutes;

1345 (3) "Physician assistant" means an individual licensed as a physician
1346 assistant pursuant to chapter 370 of the general statutes; and

1347 (4) "Sudden unexpected death in epilepsy" means the death of a
1348 person with epilepsy that is not caused by injury, drowning or other
1349 known causes unrelated to epilepsy.

1350 (b) On and after October 1, 2025, each physician, advanced practice
1351 registered nurse and physician assistant who regularly treats patients
1352 with epilepsy shall provide each such patient with information
1353 concerning the risk of sudden unexpected death in epilepsy and
1354 methods to mitigate such risk.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	19a-38
Sec. 2	*from passage*	New section
Sec. 3	*July 1, 2025*	19a-508c
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	*July 1, 2025*	19a-639
Sec. 16	*July 1, 2025*	19a-486b(b)
Sec. 17	*July 1, 2025*	19a-639f(d)

Sec. 18	*July 1, 2025*	19a-639f(j)
Sec. 19	*July 1, 2025*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	17a-667a(f)
Sec. 22	*from passage*	New section
Sec. 23	*from passage*	New section
Sec. 24	*from passage*	New section
Sec. 25	*from passage*	New section
Sec. 26	*from passage*	New section
Sec. 27	*from passage*	New section
Sec. 28	*October 1, 2025*	New section
Sec. 29	*October 1, 2025*	New section
Sec. 30	*October 1, 2025*	New section
Sec. 31	*October 1, 2025*	New section
Sec. 32	*October 1, 2025*	19a-88(e)(1)
Sec. 33	*July 1, 2025*	New section

Statement of Purpose:
To protect continued access to health care and the equitable delivery of health care services in the state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.
SEN. ANWAR, 3rd Dist.; SEN. CABRERA, 17th Dist.
SEN. COHEN, 12th Dist.; SEN. FLEXER, 29th Dist.
SEN. GADKAR-WILCOX, 22nd Dist.; SEN. GASTON, 23rd Dist.
SEN. HOCHADEL, 13th Dist.; SEN. HONIG, 8th Dist.
SEN. KUSHNER, 24th Dist.; SEN. LESSER, 9th Dist.
SEN. LOPES, 6th Dist.; SEN. MAHER, 26th Dist.
SEN. MARONEY, 14th Dist.; SEN. MARX, 20th Dist.
SEN. MCCRORY, 2nd Dist.; SEN. MILLER P., 27th Dist.
SEN. NEEDLEMAN, 33rd Dist.; SEN. RAHMAN, 4th Dist.
SEN. SLAP, 5th Dist.; SEN. WINFIELD, 10th Dist.