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:

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 Section 19a-38 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

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

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

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

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

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

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

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

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

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

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

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

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 Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If a hospital or health system charges a facility fee utilizing 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 for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Such notice shall include the following information:

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

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

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

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

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

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

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

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

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

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

(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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

with expertise in the relevant field;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Serious impairment to bodily functions; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to treat the person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Hiring and supervising such nonclinical hospital managers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*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.]

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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.
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