General Assembly **Substitute Bill No. 7**

January Session, 2025

SB00007JUD 051325

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

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

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 Section 19a-38 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the patient's health or life; or

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

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

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

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

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

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

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

(A) Complying with preferred provider network or utilization review

requirements of any program or entity authorized by state or federal law to provide insurance coverage for health care services to an enrollee; or

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

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

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

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

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

that are (i) necessary to relieve or eliminate the emergency medical condition, and (ii) within the scope of the facility's license where the physician or health care provider is providing such services, provided such services are within the scope of practice of such physician or provider.

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

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

(B) Serious impairment to bodily functions; or

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

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

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

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

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

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

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

(7) "Consultation" means the rendering of an opinion or advice, prescribing treatment or the rendering of a decision regarding

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

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

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

(b) No hospital or hospital employee and no physician or other

licensed health care provider affiliated with a hospital shall be liable under this section in any action arising out of a refusal of the hospital, hospital employee, physician or other licensed health care provider to render emergency medical services to a person if the refusal is based on the hospital's, hospital employee's, physician's or provider's determination, while exercising reasonable care, that (1) such person is not experiencing an emergency medical condition, or (2) the hospital does not have the appropriate facilities or qualified personnel available to render such services to such person.

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

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

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

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

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

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

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

(6) The records transferred with the person shall include a transfer summary signed by the transferring physician that contains relevant transfer information available to the transferring hospital at the time of transfer. The form of the transfer summary shall, at a minimum, contain (A) the person's name, address, sex, race, age, insurance status, presenting symptoms and medical condition, (B) the name and business address of the transferring physician or emergency department personnel authorizing the transfer, (C) the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient, (D) the time and date

of the transfer, (E) the reason for the transfer, (F) the time and date the person was first presented at the transferring hospital, and (G) the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent. Neither the transferring physician nor the transferring hospital shall be required to duplicate, in the transfer summary, information contained in medical records transferred with the person.

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

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

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

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

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

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

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

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

(b) The commissioner shall require as a condition of licensure of a hospital, pursuant to section 19a-491 of the general statutes, that each hospital communicate, both orally and in writing, to each person who presents to the hospital's emergency department, or such person's authorized representative, if any such representative is present and the person is unable to understand verbal or written communication, of the reasons for the transfer or refusal to provide emergency medical services and of the person's right to receive such services to stabilize an emergency medical condition prior to transfer to another hospital or health care facility or discharge without regard to ability to pay. Nothing in this subsection shall be construed to require notification of the reasons for the transfer in advance of the transfer when (1) a person is unaccompanied, (2) the hospital has made a reasonable effort to locate an authorized representative of the person, and (3) due to the person's physical or mental condition, notification is not possible. Each hospital shall prominently post a sign in its emergency department informing the public of their rights under sections 3 to 12, inclusive, of this act. Both the written communication and sign required under this

subsection shall include the contact information for the Department of Public Health and identify the department as the state agency to contact if a person wishes to complain about the hospital's conduct.

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

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

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

(c) Each receiving hospital, physician and licensed emergency room health care personnel at the receiving hospital, and each licensed emergency medical services personnel, as defined in section 19a-175 of the general statutes, effectuating the transfer of a person who knows of an apparent violation of any provision of sections 4 to 11, inclusive, of this act or the regulations adopted pursuant to section 6 of this act, shall, and each transferring hospital and each physician and other provider involved in the transfer at such hospital may, report such violation to the Department of Public Health, in a form and manner prescribed by the Commissioner of Public Health, not later than fourteen days after the occurrence of such violation. When two or more persons required to report a violation have joint knowledge of an apparent violation, a

single report may be made by a member of the hospital personnel selected by mutual agreement in accordance with hospital protocols. Any person required to report a violation who disagrees with a proposed joint report shall report individually.

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

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

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

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

medical condition or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. Each hospital shall adopt a policy to implement the provisions of this section.

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

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

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

loss of wages in addition to any compensatory damages for which the hospital or health care entity is liable under this subsection.

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

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

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

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

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

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

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

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

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

(6) "Qualified person" means a person who is a resident of a state that

has enacted laws that limit such person's access to reproductive health care services or gender-affirming health care services; and

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

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

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

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

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

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

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

designee; and

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

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

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

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

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

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

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

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

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

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

each of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Hiring and supervising such nonclinical hospital managers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PH *Joint Favorable Subst.*

JUD *Joint Favorable*