OLR Bill Analysis

sSB 7

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

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SUMMARY

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

EFFECTIVE DATE: Various; see below.

§ 1 — WATER FLUORIDATION

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

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

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

EFFECTIVE DATE: Upon passage

Background — Related Bill

SB 1326 (File 288), favorably reported by the Public Health

Committee, contains substantially similar provisions on water fluoridation.

§ 2 — FEDERAL RECOMMENDATION ADVISORY COMMITTEE

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

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

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

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

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

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

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

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

EFFECTIVE DATE: Upon passage

§§ 3 & 12 — LIMITS ON DISCIPLINING PROVIDERS

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

The bill prohibits health care entities, under certain conditions, from

limiting a health care provider's ability to give patients comprehensive, medically accurate information or counseling about reproductive or gender-affirming health care services, or about related community services and resources.

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

1. giving this information or counseling;

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

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

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

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

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

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

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

EFFECTIVE DATE: July 1, 2025

Reproductive or Gender-Affirming Care Information or Counseling

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

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

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

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

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

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

Emergency Medical Services Generally

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

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

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

Emergency Rooms

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

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

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

Transfers

The bill prohibits health care entities from firing or disciplining a

provider for refusing to transfer a patient when the provider determines, with reasonable medical probability, that the transfer or resultant delay will create a "medical hazard" (a material decline in or jeopardy to the patient's condition or recovery chances).

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

Private Right of Action

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

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

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

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

§§ 4-12 — EMTALA

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

The bill codifies into state law generally similar provisions as the federal Emergency Medical Treatment and Labor Act (EMTALA, see *Background — EMTALA*). In general, these provisions require hospitals to screen and treat patients who present to the emergency department

with emergency medical conditions, or arrange for their appropriate transfer, regardless of their ability to pay.

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

EFFECTIVE DATE: July 1, 2025

Required Emergency Treatment (§ 5)

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

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

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

Transfers (§ 6)

The bill prohibits hospitals from transferring anyone needing

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

The bill requires the DPH commissioner to adopt implementing regulations.

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

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

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

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

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

Medical Records and Test Results. The hospital must compile and transfer the person's pertinent medical records and copies of diagnostic

test results that are reasonably available. This may be done through a physical transfer or by confirming that the receiving hospital can access the transferring hospital's electronic records.

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

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

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

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

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

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

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

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

Receiving Hospital (§ 7)

The bill requires a receiving hospital to accept transfers from a transferring hospital as required by the above provisions or under any contractual obligation to care for the patient. The hospital must provide

personnel and equipment reasonably required by the applicable standard of practice and the regulations DPH must adopt (see above) to care for the transferred patient.

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

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

Conditions of Hospital Licensure (§ 8)

Policies and Protocols. Under the bill, DPH must require, as a condition of a hospital's licensure, that hospitals each adopt policies and transfer protocols consistent with the bill and the required transfer regulations. Hospitals must collaborate with their medical staff when doing so.

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

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

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

an authorized representative.

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

Recordkeeping and Reporting (§ 9)

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

Reporting Violations and Protection Against Retaliation (§ 9)

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

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

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

DPH Investigations and Disciplinary Action (§ 10)

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

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

Non-Discrimination (§ 11)

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

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

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

provisions.

Private Right of Action (§ 12)

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

Background — EMTALA

EMTALA requires every hospital with an emergency department that participates in Medicare to screen and treat patients with emergency medical conditions or arrange for their appropriate transfer if they are unable to do so. They must do this regardless of a person's income, insurance status, or other factors (e.g., immigration status, race, or religion). Hospitals and providers who fail to comply are subject to civil penalties and termination from Medicare or Medicaid (42 U.S.C. § 1395dd and 42 C.F.R. § 1003.500).

Background — Related Bills

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

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

§ 13 — SAFE HARBOR ACCOUNT

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

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

The board must spend the account's funds to award grants, in line

with policies and procedures it adopts, to the following:

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

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

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

EFFECTIVE DATE: July 1, 2025

Board of Trustees

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

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

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

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

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

Board Policies and Procedures

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

The bill allows the board, as it deems necessary, to update the policies and procedures. It also allows the board to make a fact-based eligibility determination if it decides that the policies and procedures are inadequate to determine (1) a particular provider's or organization's eligibility or (2) whether a provider or nonprofit may use grant money to reimburse or pay for a certain service or collateral cost.

§§ 14 & 15 — OPIOID USE DISORDER

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

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

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

EFFECTIVE DATE: Upon passage

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

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

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

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

EFFECTIVE DATE: Upon passage

Program Components

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

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

Program Objectives and Reporting

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

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

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

Background — Priority School Districts

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

Background — Outpatient Mental Health Treatment for Minors

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

Under the law, a provider may notify a parent or guardian of this treatment without the minor's consent or notification if the (1) provider determines that notification or disclosure is necessary for the minor's well-being, (2) treatment is solely for mental health and not for a

substance use disorder, and (3) minor is given an opportunity to object to the notification or disclosure.

§§ 18 & 19 — PUBLIC HEALTH URGENT COMMUNICATION ACCOUNT

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

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

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

EFFECTIVE DATE: Upon passage

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

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

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

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

EFFECTIVE DATE: Upon passage

§§ 22-26 — HOSPITAL ADMINISTRATOR LICENSURE

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

The bill creates a DPH licensure program for hospital administrators

("health care administrators") and sets the criteria for licensure and disciplinary action.

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

EFFECTIVE DATE: October 1, 2025

Health Care Administrator Defined (§ 22)

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

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

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

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

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

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

1. hiring and supervising these managers,

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

3. setting policies and procedures for patient care standards,

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

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

Standard Licensure and Licensure Without Examination (§ 24)

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

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

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

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

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

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

License Renewal (§§ 24 & 26)

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

The bill requires the commissioner to adopt regulations setting these requirements, defining qualifying programs, setting a control and

reporting system, and allowing for continuing education waivers for good cause.

Enforcement and Disciplinary Action (§ 25)

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

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

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

3. aiding or abetting a provider in practicing his or her profession after a patient complaint or adverse event was reported to the hospital, DPH, or the appropriate disciplining authority, while the complaint or event was being investigated, and if patient harm, disability, or death occurred after the complaint or report;

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

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

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

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

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

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

§ 27 — SUDEP INFORMATION

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

Starting October 1, 2025, the bill requires physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) who regularly treat patients with epilepsy to inform them about sudden unexpected death in epilepsy (SUDEP, which is death among people with epilepsy not caused by injury, drowning, or other known unrelated causes). Specifically, they must give them information on the risks of SUDEP and ways to mitigate those risks.

EFFECTIVE DATE: July 1, 2025

COMMITTEE ACTION

Public Health Committee

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