1 S.205

2 Introduced by Senators Brock, Ingalls and Parent

3 Referred to Committee on

4 Date:

5 Subject: Health; health care reform; health insurance; telemedicine; pharmacy
6 benefit managers; medical malpractice; accountable care
7 organizations

8 Statement of purpose of bill as introduced: This bill proposes to eliminate a
9 requirement that health insurers reimburse health care providers the same
10 amounts for services provided in person and using telemedicine through plan
11 year 2025 and would allow out-of-state providers to treat Vermont patients
12 using telemedicine. The bill would direct the Agency of Human Services to
13 seek a federal waiver to expand eligibility for catastrophic health plans in
14 Vermont and would also require the Agency to propose a design for a State
15 reinsurance program. It would authorize health insurers in Vermont to charge
16 increased premiums to individuals who use tobacco and would expand access
17 to association health plans. The bill would prohibit certain practices by
18 pharmacy benefit managers and would create certain credit protections for
19 patients with medical debt. The bill would establish limits on the amount of
20 damages recoverable in medical malpractice actions and would establish
21 screening panels for medical malpractice claims. It would direct the Auditor of

1 Accounts to report annually on hospitals' compliance with federal price
2 transparency requirements and would direct accountable care organizations to
3 make records available to the Auditor's Office upon request. The bill would
4 also direct the Green Mountain Care Board to establish specific performance
5 targets that accountable care organizations would need to meet in order to be
6 recertified to operate in Vermont.

7 An act relating to making certain reforms to Vermont's health care system

8 It is hereby enacted by the General Assembly of the State of Vermont:
9 * * * Short Title and Legislative Findings * * *
10 Sec. 1. SHORT TITLE
11 This act shall be known and may be cited as the "Vermont Insurance
12 Stabilization and Patient Affordability Act" or "VISPA."
13 Sec. 2. FINDINGS
14 The General Assembly finds that:
15 (1) Since 2016, the average premium for the second-lowest-cost silver-
16 level qualified health plan in Vermont, the plan that serves as the State's
17 benchmark plan, has increased by 40 percent.
18 (2) Vermont has among the highest unsubsidized health insurance
19 premiums for younger adults in the entire nation.

1 (3) Wide deviations exist among the cost of different health insurance
2 options in Vermont.
3 (4) Vermont is among the minority of states in the Northeast region that
4 have not implemented a prospective reinsurance program.
5 (5) Vermont is one of only two states in the United States that does not
6 consider either age or tobacco use in pricing health insurance premiums.
7 (6) Medical expenses are the most frequent reason for personal
8 bankruptcy declarations in the United States.
9 (7) Vermont has among the most restrictive certificate of need laws in
10 the United States.
11 (8) The Vermont Department of Health's 2018 Physician Census report
12 found that 29 percent of Vermont physicians are 60 years of age or older, with
13 36 percent of primary care physicians in Vermont falling into that age group.
14 (9) Vermont is facing a shortage of primary care providers, mental
15 health providers, registered nurses, and other health care professionals.
16 (10) The uninsured rate among young adult Vermonters is as much as
17 three times the statewide average uninsured rate.

* * * Telemedicine * * *

Sec. 3. 8 V.S.A. § 4100k is amended to read:

§ 4100k. COVERAGE OF HEALTH CARE SERVICES DELIVERED THROUGH TELEMEDICINE AND BY STORE-AND-FORWARD MEANS

(a)(1) All health insurance plans in this State shall provide coverage for health care services and dental services delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. A health insurance plan shall not require a health care provider to have previously conducted an in-person examination or consultation with a patient prior to delivering health care services to the patient through telemedicine.

(2)~~(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.~~

~~(B) The provisions of subdivision (A) of this subdivision (2) shall not apply:~~

1 ~~(i) to services provided pursuant to the health insurance plan's~~
2 ~~contract with a third-party telemedicine vendor to provide health care or dental~~
3 ~~services; or~~
4 ~~(ii) in the event that a health insurer and health care provider enter~~
5 ~~into a value-based contract for health care services that include care delivered~~
6 ~~through telemedicine or by store-and-forward means.~~ [Repealed.]
7 * * *
8 (i) As used in this subchapter:
9 (1) "Distant site" means the location of the health care provider
10 delivering services through telemedicine at the time the services are provided,
11 regardless of whether that location is within or outside Vermont.
12 * * *
13 Sec. 4. 18 V.S.A. § 9361 is amended to read:
14 § 9361. HEALTH CARE PROVIDERS DELIVERING HEALTH CARE
15 SERVICES THROUGH TELEMEDICINE OR BY STORE-AND-
16 FORWARD MEANS
17 (a) As used in this section~~, "distant~~:
18 (1) "Distant site," ~~"health care provider,"~~ "originating site," "store and
19 forward," and "telemedicine" ~~shall~~ have the same meanings as in 8 V.S.A.
20 § 4100k.

1 (2) "Health care provider" means a person, partnership, or corporation,
2 other than a facility or institution, that is licensed, certified, or otherwise
3 authorized by law to provide professional health care services, including dental
4 services, to an individual during that individual's medical care, treatment, or
5 confinement.
6 (b)(1) Subject to the limitations of the license under which the individual is
7 practicing, a health care provider licensed in this State may prescribe, dispense,
8 or administer drugs or medical supplies, or otherwise provide treatment
9 recommendations to a patient after having performed an appropriate
10 examination of the patient in person, through telemedicine, or by the use of
11 instrumentation and diagnostic equipment through which images and medical
12 records may be transmitted electronically. A health care provider shall not be
13 required to have previously conducted an in-person examination or
14 consultation with a patient prior to delivering health care services to the patient
15 through telemedicine. Treatment recommendations made via electronic
16 means, including issuing a prescription via electronic means, shall be held to
17 the same standards of appropriate practice as those in traditional provider-
18 patient settings.
19 (2)(A) To the extent not expressly prohibited or limited by federal law
20 or by the provisions of a relevant interstate compact, and notwithstanding any
21 provision of Vermont's professional licensure statutes or rules to the contrary,

1 a health care provider who holds a valid license, certificate, or registration to
2 provide health care services in any other U.S. jurisdiction shall be deemed to
3 be licensed, certified, or registered to provide health care services to a patient
4 located in Vermont through telemedicine in accordance with this section,
5 provided the health care provider:
6 (i) is licensed, certified, or registered in good standing in the other
7 U.S. jurisdiction or jurisdictions in which the health care provider holds a
8 license, certificate, or registration;
9 (ii) has never held a license, certificate, or registration to provide
10 health care services that has been subject to discipline by the licensing agency,
11 excluding any action related to nonpayment of fees related to a license,
12 certificate, or registration;
13 (iii) is not affirmatively barred from practice in Vermont for
14 reasons of fraud or abuse, patient care, or public safety;
15 (iv) complies with applicable requirements regarding maintenance
16 of liability insurance; and
17 (v) has never had a controlled substance license or permit
18 suspended or revoked by a U.S. jurisdiction or by the U.S. Drug Enforcement
19 Administration.
20 (B) A health care provider who delivers health care services in
21 Vermont through telemedicine is deemed to consent to, and shall be subject to,

1 the regulatory and disciplinary jurisdiction of the Board of Medical Practice or
2 the Office of Professional Regulation, as applicable based on the health care
3 provider's profession.

4 * * *

5 * * * Tobacco Rating * * *

6 Sec. 5. 33 V.S.A. § 1811 is amended to read:

7 § 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL
8 EMPLOYERS

9 * * *

10 (f)(1) A registered carrier shall use a community rating method acceptable
11 to the Commissioner of Financial Regulation for determining premiums for
12 health benefit plans. Except as provided in subdivision (2) of this subsection,
13 the following risk classification factors are prohibited from use in rating
14 individuals, small employers, or employees of small employers, or the
15 dependents of such individuals or employees:

16 (A) demographic rating, including age and gender rating;

17 (B) geographic area rating;

18 (C) industry rating;

19 (D) medical underwriting and screening;

20 (E) experience rating;

21 (F) tier rating; or

1 (G) durational rating.

2 (2)(A) The Commissioner of Financial Regulation shall, by rule, adopt
3 standards and a process for permitting registered carriers to use one or more
4 risk classifications in their community rating method, including permitting
5 registered carriers to vary the premium rate due to tobacco use by a rating
6 factor up to 1.5:1, provided that the premium charged shall not deviate above
7 or below the community rate filed by the carrier by more than 20 percent and
8 provided further that the Commissioner of Financial Regulation's rules may
9 not permit any medical underwriting and screening and shall give due
10 consideration to the need for affordability and accessibility of health insurance.

11 * * *

12 * * * Catastrophic Plans; Waiver * * *

13 Sec. 6. CATASTROPHIC PLANS; STATE INNOVATION WAIVER

14 On or before September 1, 2022, the Agency of Human Services shall apply
15 to the Secretary of the U.S. Department of Health and Human Services for a
16 State Innovation Waiver pursuant to 42 U.S.C. § 18052 to expand eligibility
17 for enrollment in a catastrophic plan under 42 U.S.C. § 18022(e) to individuals
18 who have not attained 40 years of age prior to the beginning of the plan year.
19 The Agency may adjust this maximum age if it determines that doing so is
20 necessary to achieve the actuarial requirements for obtaining the State

1 Innovation Waiver, provided that the Agency shall not reduce the maximum
2 age of eligibility to less than 30 years of age.
3 * * * Association Health Plans * * *
4 Sec. 7. 8 V.S.A. § 4079a is amended to read:
5 § 4079a. ASSOCIATION HEALTH PLANS
6 * * *
7 (b) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25
8 regulating association health plans in order to protect Vermont consumers and
9 promote the stability of Vermont's health insurance markets, to the extent
10 permitted under federal law, including rules regarding licensure, solvency and
11 reserve requirements, and rating requirements. The Commissioner's rules shall
12 not:
13 (1) require any person selling a health plan on behalf of an association to
14 provide a crosswalk of benefits comparing the association health plan with
15 plans offered on the Vermont Health Benefit Exchange or with any other plan;
16 (2) require an association or multiple employer welfare arrangement to
17 have operated continuously for any period of time in order to offer a self-
18 insured health benefit plan;
19 (3) impose requirements regarding the number of employees or paid
20 employer members involved with the association or multiple employer welfare
21 arrangement; or

1 (4) impose any medical loss ratio requirements on a self-insured
2 association plan or self-insured multiple employer welfare arrangement.
3 (c) The provisions of section 3661 of this title shall apply to association
4 health plans.
5 (d)(1) An association health plan that provided coverage for the 2019 plan
6 year may be renewed for coverage of existing association employer members
7 for subsequent plan years, to the extent permitted under federal law. An
8 association health plan that provided coverage for the 2019 plan year shall not
9 enroll any new employer members for coverage after the 2019 plan year;
10 provided, however, that new employees of existing association employer
11 members may enroll in the plan in a subsequent plan year pursuant to an offer
12 of coverage from their employer.
13 (2) No new association health plans shall be offered or issued for
14 coverage in this State for plan years 2020 and after.
15 (3) This subsection does not apply to association health plans that were
16 formed or could have been formed under the Employee Retirement Income
17 Security Act of 1974, 29 U.S.C. § 1901, et. seq., and accompanying U.S.
18 Department of Labor regulations and guidance, in each case, as in effect as of
19 January 19, 2017.

* * * Pharmacy Benefit Managers; Prohibited Practices * * *

Sec. 8. 18 V.S.A. § 9472 is amended to read:

§ 9472. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO HEALTH INSURERS

* * *

(d) ~~At least annually, a pharmacy benefit manager that provides pharmacy benefit management for a health plan shall disclose to the health insurer, the Department of Financial Regulation, and the Green Mountain Care Board the aggregate amount the pharmacy benefit manager retained on all claims charged to the health insurer for prescriptions filled during the preceding calendar year in excess of the amount the pharmacy benefit manager reimbursed pharmacies.~~ A pharmacy benefit manager shall not:

(1) charge a health insurer any amount for a prescription that exceeds the amount the pharmacy benefit manager reimbursed or will reimburse the pharmacy for filling the prescription;

(2) restrict a plan beneficiary from filling a prescription at a pharmacy of the plan beneficiary's choice; or

(3) impose different cost-sharing requirements based on the beneficiary's choice of pharmacy or otherwise promote the use of one pharmacy over another.

(e) Neither a health insurer nor a pharmacy benefit manager shall fail to include any amounts paid by a beneficiary or on behalf of a beneficiary by another party when calculating the beneficiary's total contribution to an out-of-pocket maximum, deductible, co-payment, coinsurance, or other cost-sharing requirement.

(f) Compliance with the requirements of this section is required for pharmacy benefit managers entering into contracts with a health insurer in this State for pharmacy benefit management in this State.

Sec. 9. 18 V.S.A. § 9473 is amended to read:

§ 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO PHARMACIES

* * *

(b) A pharmacy benefit manager or other entity paying pharmacy claims shall not:

(1) impose a higher co-payment for a prescription drug than the co-payment applicable to the type of drug purchased under the ~~insured's~~ beneficiary's health plan;

(2) impose a higher co-payment for a prescription drug than the maximum allowable cost for the drug;

(3) require a pharmacy to pass through any portion of the ~~insured's~~ beneficiary's co-payment to the pharmacy benefit manager or other payer;

(4) prohibit from or penalize a pharmacy or pharmacist for providing information to ~~an insured~~ a beneficiary regarding the insured's cost-sharing amount for a prescription drug; ~~or~~

(5) prohibit from or penalize a pharmacy or pharmacist for the pharmacist or other pharmacy employee disclosing to ~~an insured~~ a beneficiary the cash price for a prescription drug or selling a lower cost drug to the ~~insured~~ beneficiary if one is available;

(6) prohibit from or penalize a pharmacy or pharmacist for disclosing to a beneficiary the pharmacy's acquisition cost for a prescription drug or the amount the pharmacy was reimbursement for the drug;

(7) condition a pharmacy's or pharmacist's reimbursement for dispensing prescription drugs in any way based on whether the pharmacy or pharmacist participates in the health insurer's or pharmacy benefit manager's network or on any other contractual agreement; or

(8) directly or indirectly reduce the amount of a reimbursement to a pharmacy or pharmacist for dispensing a prescription drug after adjudication of the claim through the use of an aggregated effective rate, quality assurance program, indirect remuneration fee, or by any other mechanism.

* * *

1 * * * Medical Malpractice Actions * * *

2 Sec. 10. 12 V.S.A. § 1914 is added to read:

3 § 1914. MEDICAL MALPRACTICE; LIMITATIONS ON DAMAGES

4 (a) The damages awarded for pain and suffering or other noneconomic loss

5 in an action based on medical malpractice shall not exceed $250,000.00.

6 (b) The damages awarded for wrongful death in an action based on medical

7 malpractice shall not exceed the amount of $500,000.00 per claimant.

8 (c) The amount of punitive damages awarded shall not exceed $200,000.00

9 or twice the total of economic and noneconomic losses, whichever is greater.

10 Sec. 11. 12 V.S.A. chapter 219 is added to read:

11 CHAPTER 219. SCREENING PANELS FOR MEDICAL INJURY CLAIMS

12 § 7201. DEFINITIONS

13 As used in this chapter:

14 (1) "Action for medical injury" means any action against a medical care

15 provider, whether based in tort, contract, or otherwise, to recover damages on

16 account of medical injury.

17 (2) "Medical care provider" means a physician, physician assistant,

18 registered or licensed practical nurse, hospital, clinic, or other health care

19 agency licensed by the State or otherwise lawfully providing medical care or

20 services, or an officer, employee, or agent thereof acting in the course and

21 scope of employment.

1 (3) "Medical injury" means any adverse, untoward, or undesired
2 consequences arising out of or sustained in the course of professional services
3 rendered by a medical care provider, whether resulting from negligence, error,
4 or omission in the performance of such services; from rendition of such
5 services without informed consent or in breach of warranty or in violation of
6 contract; from failure to diagnose; from premature abandonment of a patient or
7 of a course of treatment; from failure properly to maintain equipment or
8 appliances necessary to the rendition of such services; or otherwise arising out
9 of or sustained in the course of such services.

10 § 7202. FORMATION AND PROCEDURE

11 (a) The Supreme Court shall maintain a list of retired judges, persons with
12 judicial experience, and other qualified persons to serve on screening panels
13 under this chapter, from which the Chief Justice shall choose a panel chair
14 under subsection (b) of this section. The Court shall maintain lists of health
15 care practitioners and attorneys with litigation experience, recommended by
16 their respective professional organizations to serve on screening panels under
17 this chapter. As directed by the Court, the professional organization of each
18 profession shall inform the Court of the names of volunteers to serve on
19 panels.

1 (b) Screening panel members shall be selected as follows:
2 (1) Upon the entry of a medical injury case, the clerk of the Superior
3 Court in which the medical injury case is filed shall notify the Chief Justice of
4 the Supreme Court.
5 (2) Within 14 days following the service date specified by the court on
6 the summons, the Chief Justice shall choose a retired judge, a person with
7 judicial experience, or other qualified person from the list maintained by the
8 Chief Justice to serve as chair of the panel to screen the claim. If at any time
9 the Chair chosen under this subsection is unable or unwilling to serve, the
10 Chief Justice shall appoint a replacement following the procedure in this
11 subsection for the initial appointment of the Chair. Persons other than retired
12 judges or those with judicial experience may be appointed as Chair based on
13 appropriate trial experience. If the Chief Justice appoints as Chair a person
14 who is not a retired judge or who does not have judicial experience, each side
15 may make one challenge to the appointment.
16 (3) The Chief Justice shall notify the clerk of the name of the person
17 designated to serve as Chair and shall provide the clerk with the lists of health
18 care practitioners and attorneys maintained under this section. Upon
19 notification of the Chief Justice's choice of chair, the clerk shall notify the
20 Chair and the parties and provide them with the lists of health care

1 practitioners and attorneys. The Chair shall choose two or three additional
2 panel members from the lists as follows:
3 (A) One attorney.
4 (B) One health care practitioner. If possible, the Chair shall choose a
5 practitioner who practices in the same specialty or profession as the person or
6 entity accused of professional negligence.
7 (C) Where the claim involves more than one person accused of
8 professional negligence, the Chair may choose a fourth panel member who is a
9 health care practitioner. If possible, the Chair shall choose a practitioner or
10 provider in the specialty or profession of a person accused.
11 (D) When agreed upon by all the parties, the list of available panel
12 members may be enlarged in order to select a panel member who is agreed to
13 by the parties but who is not on the Chief Justice's list.
14 (4) The screening panel process is not intended to delay or postpone the
15 trial of a medical injury case. The Superior Court may establish a trial date at a
16 structuring conference, or other scheduling conference, and all interim
17 deadlines as it would in any other case.
18 (5) The Supreme Court shall establish the compensation of the panel
19 Chair if the individual appointed is not otherwise compensated by the State.
20 Other panel members shall serve without compensation or payment of
21 expenses.

1 (6) The clerk of the Superior Court in the unit in which a medical injury
2 case is filed shall, with the consent of the Supreme Court, provide clerical and
3 other assistance to the panel Chair.
4 (7) Only challenges for cause shall be allowed. If a panel member other
5 than the Chair is challenged for cause, the party challenging the member shall
6 notify the panel Chair. If the panel Chair finds cause for the challenge, the
7 Chair shall replace the panel member. If the Chair is challenged for cause, the
8 party challenging the Chair shall notify the Supreme Court. If the Chief
9 Justice finds cause for the challenge, the Chief Justice shall replace the Chair.
10 (8) The panel, through the Chair, shall have the same subpoena power as
11 exists for a Superior Judge. The Chair shall have sole authority, without
12 requiring the agreement of other panel members, to issue subpoenas.
13 (9) The Vermont Rules of Civil Procedure shall govern discovery
14 conducted under this chapter. The parties shall attempt in good faith to resolve
15 discovery issues themselves. The Chair shall rule on disputes regarding
16 discovery. Any person aggrieved by a Chair's ruling regarding discovery may
17 appeal to the Civil Division of the Superior Court, which shall defer to the
18 Chair's factual findings unless they are clearly erroneous.
19 § 7203. PANEL PROCEDURES
20 (a) All documents filed with the court in a medical injury action that are
21 part of the screening process are confidential.

1 (b) Within 20 days of the service date specified by the court on the
2 summons, the person or persons accused shall contact the claimant's counsel
3 and by agreement shall designate a timetable for filing all the relevant medical
4 and provider records necessary to a determination by the panel. If the parties
5 are unable to agree on a timetable within 60 days of the service date specified
6 by the court on the summons, the claimant shall notify the Chair of the panel.
7 The Chair shall then establish a timetable for the filing of all relevant records
8 and reasonable discovery, which shall be filed at least 30 days before any
9 hearing date. The hearing shall be not later than six months from the service
10 date specified by the court on the summons, except when the time period has
11 been extended by the panel Chair in accordance with this chapter.
12 (c) The pretrial screening may be bypassed if all parties agree upon a
13 resolution of the claim by trial.
14 (d) All parties to a claim may, by written agreement, submit a claim to the
15 binding determination of the panel. Both parties may agree to bypass the panel
16 for any reason or may request that certain preliminary legal affirmative
17 defenses or issues be litigated prior to submission of the case to the panel. The
18 panel shall have no jurisdiction to hear or decide, absent agreement of the
19 parties, dispositive legal affirmative defenses, other than comparative
20 negligence. The panel Chair may require the parties to litigate, by motion,
21 dispositive legal affirmative defenses in the Civil Division of the Superior

1 Court prior to submission of the case to the panel. Any such defense, as well
2 as any motion relating to discovery that the panel Chair has chosen not to rule
3 on, may be presented by motion in Superior Court.
4 (e) Except as otherwise provided in this section, there shall be one
5 combined hearing for all claims under this section arising out of the same set
6 of facts. When a medical injury case has been filed against more than one
7 person accused of medical injury based on the same facts, the parties may,
8 upon agreement of all parties, require that hearings be separated. The Chair
9 may, for good cause, order separate hearings.
10 (f) All requests for extensions of time under this section shall be made to
11 the panel Chair. The Chair may extend any time period for good cause, except
12 that the Chair may not extend any time period that would result in the hearing
13 being held more than 11 months following the service date specified by the
14 court on the summons, unless good cause is shown.
15 (g)(1)(A) On failure of the plaintiff to prosecute or to comply with rules or
16 any order of the Chair or if the plaintiff fails to attend a properly scheduled
17 hearing, and on motion by the Chair or any party, after notice to all parties has
18 been given and the party against whom sanctions are proposed has had the
19 opportunity to be heard and show good cause, the Chair may order appropriate
20 sanctions, which may include dismissal of the case. If any sanctions are

1 imposed, the Chair shall state the sanctions in writing and include the grounds
2 for the sanctions.
3 (B) Unless the Chair or the panel in an order for dismissal specifies
4 otherwise, a dismissal under this subdivision (1) is with prejudice for purposes
5 of proceedings before the panel. A dismissal with prejudice is the equivalent
6 of a finding for the defendant on all issues before the panel.
7 (2)(A) On failure of a defendant to comply with the rules or any order of
8 the Chair, or if a defendant fails to attend a properly scheduled hearing, and on
9 motion by the Chair or any party, after notice to all parties has been given and
10 the party against whom sanctions are proposed has had the opportunity to be
11 heard and show good cause, the Chair may order appropriate sanctions, which
12 may include default. If any sanctions are imposed, the Chair shall state the
13 sanctions in writing and include the grounds for the sanctions.
14 (B) Unless the Chair or the panel in its order for default specifies
15 otherwise, a default under this subdivision (2) is the equivalent of a finding
16 against the defendant on all issues before the panel.
17 (3) Any person aggrieved by a Chair's ruling regarding sanctions may
18 appeal to the Superior Court, which shall defer to the Chair's factual findings
19 unless they are clearly erroneous.

1 § 7204. HEARING

2 (a)(1) The claimant or a representative of the claimant shall present the
3 case before the panel. The person accused of professional negligence or that
4 person's representative shall make a responding presentation. The panel shall
5 afford the parties wide latitude in the conduct of the hearing, including the
6 right of examination and cross-examination by attorneys. Depositions are
7 admissible whether or not the person deposed is available at the hearing. The
8 Chair shall make all procedural rulings, which shall be final. The Vermont
9 Rules of Evidence shall not apply. Evidence shall be admitted if it is the kind
10 of evidence upon which reasonable persons are accustomed to rely in the
11 conduct of serious affairs. The panel shall make findings upon evidence
12 presented at the hearing, the records, and any expert opinions provided by or
13 sought by the panel or the parties.

14 (2) After presentation by the parties, the panel may request additional
15 facts, records, or other information from either party to be submitted in writing
16 or at a continued hearing, which continued hearing shall be held as soon as
17 possible. The continued hearing shall be attended by the same members of the
18 panel who have sat on all prior hearings in the same claim, unless otherwise
19 agreed by all parties. Replacement panel members shall be appointed pursuant
20 to this chapter.

1 (b) The panel shall maintain an electronically recorded record. Except as
2 provided in section 7207 of this title, the record may not be made public, and
3 the hearings may not be public without the consent of all parties.
4 (c) The Chair of the panel shall attempt to mediate any differences of the
5 parties before proceeding to findings.
6 § 7205. FINDINGS BY PANEL
7 (a) At the conclusion of the presentations, the panel shall make its findings
8 regarding negligence and causation in writing within 30 days by answering the
9 following questions:
10 (1) whether the acts or omissions complained of constitute a deviation
11 from the applicable standard of care by the medical care provider charged with
12 that care;
13 (2) whether the acts or omissions complained of proximately caused the
14 injury complained of; and
15 (3) if fault on the part of the medical care provider is found, whether any
16 fault on the part of the patient was equal to or greater than the fault on the part
17 of the provider.
18 (b) The standard of proof used by the panel shall be as follows:
19 (1) The plaintiff shall prove negligence and proximate causation by a
20 preponderance of the evidence.

1 (2) The defendant shall prove comparative negligence by a
2 preponderance of the evidence.
3 § 7206. NOTIFICATION OF FINDINGS
4 The panel's findings, signed by the panel members, indicating their vote,
5 shall be sent by registered or certified mail to the parties within seven days
6 following the date of the findings. The findings and record of the hearing shall
7 be preserved until 30 days after final judgment or final resolution of the case,
8 after which time they shall be destroyed. All medical and provider records
9 shall be returned to the party providing them to the panel.
10 § 7207. CONFIDENTIALITY AND ADMISSIBILITY
11 (a) Except as otherwise provided in this section, all proceedings before the
12 panel, including its final determinations, shall be treated as private and
13 confidential by the panel and the parties to the claim.
14 (1) The findings and other writings of the panel and any evidence and
15 statements made by a party or a party's representative during a panel hearing
16 are not admissible in court, shall not be submitted or used for any purpose in a
17 subsequent trial, and shall not be publicly disclosed, except as follows:
18 (A) Any testimony or writings made under oath may be used in
19 subsequent proceedings for purposes of impeachment.
20 (B) The party who made a statement or presented evidence may
21 agree to the submission, use, or disclosure of that statement or evidence.

1 (2) If the panel findings as to both the questions under subdivisions
2 7205(a)(1) and (2) of this title are unanimous and unfavorable to the defendant,
3 the findings are admissible in any subsequent trial of the medical injury case.
4 (3) If the panel findings as to any question under subsection 7205(a) of
5 this title are unanimous and unfavorable to the plaintiff, the findings are
6 admissible in any subsequent trial of the medical injury case.
7 (b) The confidentiality provisions of this section shall not apply if the
8 findings were influenced by fraud.
9 (c) The deliberations and discussion of the panel and the testimony of any
10 expert, whether called by a party or the panel, shall be privileged and
11 confidential, and no such person shall be asked or compelled to testify at a later
12 court proceeding concerning the deliberations, discussions, findings, or expert
13 testimony or opinions expressed during the panel hearing, unless by the party
14 who called and presented the nonparty expert, except such deliberation,
15 discussion, and testimony as may be required to prove an allegation of fraud.
16 § 7208. MANDATORY INSTRUCTIONS
17 (a) When panel findings are offered and admitted into evidence in a
18 subsequent court action in accordance with section 7207 of this title, the Court
19 shall provide the following information to the jury to provide a basis for the
20 jury to understand the nature of the panel findings and to put the panel findings
21 in context in evaluating all of the evidence presented at the trial:

1 (1) The panel process is a preliminary procedural step through which
2 malpractice claims proceed.
3 (2) The panel in this case consisted of (insert the name and identity of
4 the members).
5 (3) The panel conducts a summary hearing and is not bound by the rules
6 of evidence.
7 (4) The hearing is not a substitute for a full trial and may or may not
8 have included all of the evidence that is presented at the trial.
9 (5) The jury is not bound by the findings of the panel, and it is the
10 jurors' duty to reach their own conclusions based on all of the evidence
11 presented to them.
12 (6) The panel proceedings are privileged and confidential.
13 Consequently, the parties shall not introduce panel documents or present
14 witnesses to testify about the panel proceedings, and they may not comment on
15 the panel findings or proceedings except as provided in subdivisions (1)
16 through (5) of this subsection.
17 (b) The information specified in subsection (a) of this section shall be
18 provided to the jury when the findings are admitted into evidence and when the
19 Court instructs the jury prior to submitting the case to the jury.

1 § 7209. EFFECT OF PANEL FINDINGS
2 Unanimous findings entered by the panel under subsection 7205(a) of this
3 title shall be implemented as follows:
4 (1) If findings are in the plaintiff's favor, the defendant shall promptly
5 enter into negotiations to pay the claim or admit liability. If liability is
6 admitted, the claim may be submitted to the panel, upon agreement of the
7 parties, for determination of damages. If the claim goes to a trial, the findings
8 of the panel are admissible as provided in subdivision 7207(a)(2) of this title.
9 (2) If the findings are in the defendant's favor, the plaintiff shall release
10 the claim or claims based on the findings, without payment, or be subject to the
11 admissibility of those findings under subdivision 7207(a)(3) of this title.
12 * * * Prospective Reinsurance Program * * *
13 Sec. 12. PROSPECTIVE REINSURANCE PROGRAM; REPORT
14 On or before September 15, 2022, the Secretary of Human Services, in
15 collaboration with the Commissioner of Financial Regulation, shall submit a
16 report to the General Assembly with a proposed design for implementing a
17 prospective reinsurance program, which shall include an analysis of the need
18 for one or more waivers pursuant to 42 U.S.C. § 18052 in order to maximize
19 federal funding.

1 * * * Accountable Care Organizations * * *
2 Sec. 13. ACCOUNTABLE CARE ORGANIZATION PERFORMANCE
3 TARGETS
4 On or before September 15, 2022, the Green Mountain Care Board shall
5 establish specific performance targets that certified accountable care
6 organizations operating in this State must meet in order to be recertified
7 pursuant to 18 V.S.A. § 9382 in the ensuing fiscal years. The targets shall
8 include requirements for improved performance on quality metrics that exceed
9 the accountable care organization's previous quality achievement levels.
10 Sec. 14. 18 V.S.A. § 9574 is added to read:
11 § 9574. ACCESS TO RECORDS
12 An accountable care organization certified pursuant to section 9382 of this
13 title shall make available to the Office of the Auditor of Accounts all records
14 of the accountable care organization, and any affiliated entity, that the Auditor,
15 in the Auditor's discretion and upon the Auditor's request, determines are
16 needed to enable the Office of the Auditor of Accounts to audit the accountable
17 care organization's financial statements, receipt and use of federal and State
18 monies, and performance.
19 * * * Effective Date * * *
20 Sec. 15. EFFECTIVE DATE
21 This act shall take effect on passage.