State of Vermont
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Report to the Legislature

Price Transparency and Billing Processes Report

In accordance with Act 53 of 2019, Section 3

Submitted to the
House Committee on Health Care, the Senate Committees on
Health and Welfare and Finance, and the Health Reform Oversight Committee

Submitted by the
Green Mountain Care Board

November 15, 2019

Glossary of Terms

Term	Definition
Charity Care	Health care provided for free or at a reduced price to low income patients.
Claim	A medical bill submitted to health insurance carriers and other insurance providers for services rendered to patients by providers.
Coinsurance	Percentage of costs of a covered health care service the patient pays after the deductible is paid.
Copayment (Copay)	Fixed amount for a covered service paid by the patient to the provider of service.
Deductible	The amount you pay for covered health care services before insurance starts to pay.
Flexible Spending Account (FSA)	A special account you put pre-tax dollars into to pay for certain out-of-pocket health care costs.
Health Savings Account (HSA)	Savings account used in conjunction with a high-deductible health insurance plan allowing the user to save tax-free money for medical expenses.
In-Network	A patient's provider has negotiated a contracted rate with the patient's health insurance coverage.
Out-of-Network	Doctor or facility providing care that does not have a contract with a patient's health insurance company.
Out-of-Pocket (OOP)	Portion of a medical bill not covered by insurance that an individual must pay on their own.
Payer	An entity that pays or administers the payment of health insurance claims or medical claims.
Population-Based Payment	Payment model rewarding providers for meeting population-level targets.
Provider	A hospital, physician, emergency room, outpatient facility or any other place medical services are performed.
Risk-Sharing Payment	Payment model based on an estimate of the expected costs to treat a condition or patient population.

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Purpose

The Green Mountain Care Board (GMCB) is charged with reducing the rate of health care cost growth in Vermont while ensuring a high quality and accessible health care system. In 2019, the Vermont legislature enacted Act 53 (S.31) which required the GMCB to "examine health care price transparency initiatives in other states to identify possible options for making applicable health care pricing information readily available to consumers in this State to help inform their health care decision making." The statute also charges the Board to "consider and provide recommendations regarding potential financial procedures for health care services that would coordinate processes between hospitals and payers without requiring the patient's involvement and would provide patients who receive hospital services with a single, comprehensive bill that reflects the patient's entire, actual financial obligation. On or before November 15, 2019, the Board shall provide its findings and recommendations pursuant to subsections (a) and (b) of this section to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee."[1]

The GMCB worked with interested stakeholders to examine transparency initiatives and consider financial procedures to coordinate billing processes between hospitals and payers. This report is intended to inform the legislature of health care transparency tools in use across the United States and explore the feasibility of a coordinated billing system in Vermont.

Part A. Health Care Price Transparency Initiatives

Section 1. Background

The Vermont legislature tasked the Green Mountain Care Board to "examine health care price transparency initiatives in other states to identify possible options for making applicable health care pricing information readily available to consumers in this State to help inform their health care decision making."

In the United States, consumers are increasingly becoming aware of price variation regarding health care services. Consequently, consumers generally support price transparency initiatives that provide the option to shop around for the highest-quality care while considering the cost. The GMCB researched and examined health care price transparency tools in other states and with the support of stakeholder consultation, outlined some best practices and next steps for consideration.

1.1 Prior Vermont Research

In 2015, in accordance with Act 54 of 2015 pertaining to consumer information and price transparency, the Board contracted with Human Services Research Institute (HSRI) and National Opinion Research Center (NORC) at the University of Chicago to examine potential options and best practices for delivering consumers health care cost and quality information on-line. In October of that year, the GMCB submitted a full report to the committees of jurisdiction[2]. The HSRI-NORC team conducted a review of existing consumer transparency sites and platforms and compared the websites to best

[1] Act 53 (2019), Sec. 3, PRICE TRANSPARENCY; BILLING PROCESSES; REPORT. Available at: https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT053/ACT053%20As%20Enacted.pdf

[2] Act 54 (2015), Sec. 21, CONSUMER INFORMATION AND PRICE TRANSPARENCY REPORT. Available at: https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-CIPTR-10012015.pdf

practices found in public reporting. The team also studied the feasibility of implementing transparency tools in Vermont. The GMCB and HSRI-NORC team reviewed 49 health transparency websites and examined the ways the sites adhered to consumer and website design best practices. Additionally, the team conducted expert interviews with thirteen directors of transparency websites, including Vermont's three major insurance carriers in 2015; Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care (MVP), and Cigna. The 2015 report provided general recommendations for a health care cost and quality information system while addressing feasibility and cost for Vermont:

Vermont Specific Considerations: Vermont should take into consideration whether creating a website aligns with the state's goals and resources. Price transparency websites are expensive to create and maintain. The 2015 research found that one state model implemented by an outside vendor cost ranged from $400,000 to $500,000 and ongoing maintenance cost about $200,000 annually[3]. In addition, we must understand the landscape in which Vermont consumers purchase health insurance and where they receive care. As noted in the report, BCBSVT, MVP, and Cigna provide a member website with timely information on an individual's OOP costs for specific providers and procedures. Insurers can also provide consumers with tailored cost estimates based on plan benefits. Another consideration is that some Vermonters receive care out of state. Of the websites examined, no state sponsored websites were able to provide cost estimates outside of state borders. These factors are essential to evaluate how transparency initiatives could be implemented in Vermont.

Possible Approaches for Vermont: Act 54 of 2015 included two approaches to informing consumers about health care prices and quality; direct individual insurer websites and for the Board to "evaluate potential models for allowing consumers to compare information about the cost and quality of health care services available in the State". The advantage to an insurer-based approach is that the insurer has information about each consumer's benefit plan such as deductibles, coinsurance, copays, and in-network/out-of-network differentials. The disadvantage is that the information is only accessible to current members. There is also a lack of standardization across plans regarding quality information. A state-based approach allows for the information to be available to everyone, regardless of insurer. A state model would also support price variation analysis for services at a facility depending on the provider.

General Recommendations: The 2015 report outlined recommendations and next steps to guide the Board should it decide to further explore a cost and quality information system:

1. Choose an approach (determine if website should be state-based).
2. Conduct a comprehensive needs assessment.
3. Clearly define goals and objectives.
4. Ensure that adequate funding and resources are available.
5. Select a financially sustainable option.
6. Implement best practices regarding data management and quality assurance processes.
7. Engage consumers throughout the process.
8. Provide information on expected out-of-pocket expenses.
9. Utilize consumer website recommended features.

[3] Act 53 (2019), Sec. 3, PRICE TRANSPARENCY; BILLING PROCESSES; REPORT. Available at: https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT053/ACT053%20As%20Enacted.pdf

Consumer website recommended features: Based on literature, best practices and common approaches, the Board provided a list of recommendations to consider if Vermont decided to pursue a health care transparency website. The eighteen feature recommendations below relate to cost reporting, quality data reporting, tools comparing cost and quality, ease of use and innovative features, and ensuring consumer access/promoting use[4].

Feature	Recommendations based on literature, best practice, and common approaches
Cost Reporting	
Data Source	Use claims data from public and private payers and update as frequently as feasible. Validate data internally and with stakeholders.
Cost Estimate	Use total amount paid for a service by both consumers and insurers; allow the user to toggle between a cost estimate and ranges. Determine whether a range, mean or median cost is desired by target audience. If possible, distinguish between the contributions from the insurer and the consumer.
Medical Services	Decide what types of services to include and whether to display estimates for single, bundled, or grouped procedures. Use the "care bundle" model where appropriate for total costs of a facility and physician charges or consider episode-based costs of care; provide a breakout of cost by component[5].
Data Display	Provide estimated price at the facility level and, if possible, the physician level. Allow users to compare and rank performance.
Transparency in cost methodology	Be sure to vet the cost methodology with providers. Offer clear, consumer-friendly terms that explain to consumers what is included in the cost estimates for a given service.
Quality Data Reporting	
Data Source	Use up-to-date, third-party data sources. Use a combination of patient experience and other nationally recognized and endorsed patient quality/safety measures (for example, the National Quality Forum measures) that have stakeholder support.
Quality Measures	Use methodologically sound quality measures that have stakeholder support and that consumers care about. Organize measures into domains. Consider patient experience and patient quality/safety measures, such as Report on Patient Experience, Complications, Deaths and Readmissions, Effectiveness, Safety, and Healthcare-Associated Infection.
Quality Estimate Display	Use symbols or word icons to convey performance instead of or in conjunction with numbers. Display performance data using a three- or five-point scale. If possible, use evaluative words embedded in the icon to tell consumers what is good or excellent care and what is not. Allow users to toggle between the symbol or word icon denoting the level of the quality measure and a numeric estimate.

[4] Act 54 (2015), Sec. 21, CONSUMER INFORMATION AND PRICE TRANSPARENCY REPORT. Available at: https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-CIPTR-10012015.pdf

[5] The costs for a given episode of care can be broken down into components, such as professional, facility, and pharmacy or could include all pre- and post-procedure services during a specified window of time.

Feature	Recommendations based on literature, best practice, and common approaches
Ease of Use and Innovative Features	
Transparency in cost methodology	Offer clear, consumer-friendly terms that explain to consumers where the quality measures come from and how they are estimated.
Additional elements	Provide access to other health care resources. Increase credibility through an "About Us" and "Contact" section and allow users to provide feedback. Define terms, especially for medical services and quality ratings.
Filters	Filter by geographical area, insurance carrier if possible, and facility type.
Procedures	Select 'shoppable'[6] medical procedures based on volume, cost variation, and prevalence within user searches. Allow for plain language searches on procedures.
Primary Search Parameter	Allow searching by condition or procedure across all facilities.
Functionality	Allow users to search site in a variety of ways (procedure type or menu driven) and for a variety of fields (facilities, quality measures, geographic area).
Ensuring Consumer Access/Promoting Use	
Branding	Use consistent branding to add credibility, improve searchability and increase user recognition.
Encourage consumer input	Develop site for consumers. Involve consumers in the visioning and development stages of the website. Include an easy channel for consumers to provide feedback on the live site. Add additional elements for researchers if necessary. Create user consumer personas to guide development and ensure accessibility.
Building an audience	Include a marketing campaign to educate consumers on both the website and how to use it. Additional education, information and awareness may encourage more usage by consumers of health care. Make results transferrable to other media such as advertisements and public service announcements.
Search engine optimization	Use search engine optimization to enable the site to appear quickly in popular search engine results. Use sponsored, or paid, search engine results.
Apps	Develop apps for the site for use on mobile phones, tablets and other electronic devices.
Syndication	Allow website content to be used on other websites.
508 Compliance and Accessibility	Develop a website that is accessible to people with disabilities.

[6] The term 'shoppable' here refers to procedures that a typical consumer would want to compare prices on, such as elective surgeries, immunizations, and treatments for chronic conditions.

Section 2. Research & Stakeholder Engagement

We examined health care price transparency sites in other states through healthcaretransparency.org and gathered stakeholder input from representatives of Vermont's health care entities for this section of the report.

2.1 Review of Price Transparency Tools

When examining health care price transparency initiatives in other states, we mainly reviewed and assessed the website healthcaretransparency.org. The New York State Health Foundation (NYSHealth) partnered with HonestHealth, along with the Informed Patient Institute to conduct a national inventory of health care transparency tools. HonestHealth then contracted with the Human Services Research Institute (HSRI) to summarize the findings and recommend next steps, which is outlined on the website. The inventory examined over 230 health care transparency tools across the nation in four categories; physicians, hospitals, prescription drug pricing, and buying health insurance[7]; below are summaries of the healthcaretransparency.org research for each category. A set of criteria was developed for each category to ensure the transparency tools were evaluated consistently and objectively.

Physician Price and Quality

For physician price and quality, 49 tools were evaluated; 26 are national sites and 23 came from 15 states and in total, 59 features were reviewed[8]. The site tools used to find a physician mostly shared quality and overall site features rather than price features. Of the features reviewed, over 70% of the tools examined included:

1) A summary view with physician information in one place
2) Explanation about the reported performance information
3) Description of quality methodology
4) Information available in a printer-friendly format

The most common clinical quality care measure is diabetes, which 33% of the sites incorporated. California has the highest number of physician sites (4), then Maine (3) and New York (2).

Physician Sites with the Most Features	Most Price Specific Features	Most Quality Specific Features
Minnesota HealthScores[9] (*S*[10]*, 45 features*)	Minnesota HealthScores (*S, 22 features)*, Compare Maine[11] (*S, 22 features*) and Amino[12] (*N*[13]*, 22 features*)	Minnesota HealthScores (*S, 23 features*), GetBetterMaine[14] (*S*) the Community Checkup[15] (*S*), and myCareCompare[16] (*S*), (*20-21 features)*

[7] HonestHealth. healthcaretransparency.org: http://www.healthcaretransparency.org/
[8] HonestHealth. "Doctor Price and Quality Details" healthcaretransparency.org: http://www.healthcaretransparency.org/physicians-all-sites-in-rows/
[9] MN HealthScores from MN Community Measurement: http://www.mnhealthscores.org/
[10] "S" denotes a state-based transparency tool
[11] Compare Maine Health Costs & Quality: https://www.comparemaine.org/
[12] Amino: https://partners.amino.com/home
[13] "N" denotes a national transparency tool
[14] Get Better Maine: (Website no longer available)
[15] Community Checkup: https://www.wacommunitycheckup.org/
[16] myCareCompare: http://www.mycarecompare.org/

Tools Featured		
• Lookup and sorting of providers • Highlights top and below average performing providers • Displays provider price and quality information	• Sources payment data from commercial claims • Uses recent payment data to show prices at provider level • Provider & price information • Facility or procedure lookup • Displays comparative price benchmarks, payment bundled prices, and total payment	• Patient surveys & clinical quality of care measures • Comparative quality benchmarks • Years of quality performance information

Hospital Price and Quality

For hospital price and quality, 133 public sites were evaluated; 18 are national sites and 115 came from 45 states, and 62 features were reviewed[17]. The site tools used to find hospital information mostly shared quality and overall site features rather than price features. At least 86% of the sites reviewed had information that is two years old or less and at least 70% of the sites featured:

1) Information available in printer-friendly formats
2) Descriptions of quality methodology
3) Information for hospitals side-by-side
4) Comparative benchmarks

The most common clinical quality care measure included is heart care, which 43% of the sites incorporate. Washington, California, Colorado, Minnesota and Virginia have at least 5 sites per state, and New York has 3 state-specific tools.

Hospital Sites with the Most Features	Most Price Specific Features	Most Quality Specific Features
Hospital Report Cards[18] (*S, 37 features*), The Hospital Guide (*S, 37*)[19], Illinois Hospital Report Card[20] (*S, 36*), and California Healthcare Compare[21] (*S, 35*)	Hospital Report Cards (*S*) and CompareMaine (*S)*	The Hospital Guide (*S*), Illinois Hospital Report Card (*S*) and Washington State MONAHRQ[22] (WaMONAHRQ) (*S*)

[17] Honest Health. "Hospital Price and Quality Details" healthcaretransparency.org: http://www.healthcaretransparency.org/hospitals-all-sites/

[18] Vermont Department of Health, Hospital Report Cards: https://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-report-cards

[19] Maryland Health Care Quality Reports, The Hospital Guide: https://healthcarequality.mhcc.maryland.gov/Article/View/d1c578b9-afab-45c2-b88a-df65e1c46fc2

[20] Illinois Hospital Report Card: http://healthcarereportcard.illinois.gov/

[21] California Healthcare Compare: (Website is no longer available, project ceased operating end of 2018). Additional information available here: https://abouthealthtransparency.org/report-card-directory/state-report-cards/california/california-healthcare-compare/

[22] Washington State MONAHRQ: http://www.wamonahrq.net/

Tools Featured		
• Sources data other than CMS data • Lookup by hospital and procedure • Recent price information for hospitals and procedures • Displays prices, including non-insurance price • Comparative benchmarks • Detailed methodology and source of price data	• Recent price information for hospitals and procedures • Displays prices, including non-insurance price	• Displays charges or cost of any type • Reporting clinical quality of care information • Indicates when data was updated

Drug Pricing

For drug pricing, 18 websites were evaluated; 15 are national and 3 are state-specific, with one site in California, Florida and New York[23]. The sites provide consumers with prescription drug prices, discounts, or direct purchases of drugs. 20 features were reviewed, and all 18 sites featured the option to lookup a prescription drug by name. The most common features include:

1) A lookup of prescription drugs including the dosage and pricing for a prescription drug by pharmacy (94%)
2) Users could view results without paying a fee or subscription (89%)
3) Generic and brand name alternatives (72%)

Drug Pricing Sites with the Most Features	Tools Featured
GoodRx[24] (*N*), California Rx Card[25] (*S*), Discount Drug Network[26] (*N*), and Drugs.com[27] (*N*), (*all with 14 features*)	• Coupons or discount cards work for pets • GoodRx includes pricing for compounded medications and sign-up for price alerts, medication savings, and price recheck *Note*: The sites did not allow users to order prescription drugs online and none linked to a Canadian pharmacy

Health Insurance Purchasing

For health insurance shopping, 36 websites were inventoried; 17 are national and 19 are from 16 states, with 3 from New York[28]. 33 features were reviewed and none of them were present on all the sites inventoried. The most common features include:

1) View of results without contact from telemarketers (75%)
2) Allows users to filter insurance company by zip code, city or state and allows the user to enter the ages of household members (69%)

[23] HonestHealth. "Details Drug Pricing". healthcaretransparency.org: http://www.healthcaretransparency.org/drugs-all-with-sites-in-rows/
[24] GoodRx: https://www.goodrx.com/
[25] California Rx Card: https://californiarxcard.com/
[26] Discount Drug Network: https://www.discountdrugnetwork.com/drug-pricing/
[27] Drugs.com: https://www.drugs.com/price-guide/
[28] HonestHealth. "Details Health Insurance Shopping Sites". healthcarepricetransparency.org: http://www.healthcaretransparency.org/insurance-purchasing-all-sites/

3) Cost of insurance plan (64%)
4) In-network and out-of-network deductibles, co-pays, and out-of-pocket (OOP) costs (61%)

Health Insurance Sites with the Most Features	Tool Features
Covered California[29] (*S, 29 features*) and MNsure[30] (*S, 25*)	• Online sign-up for insurance and other alerts • Show in-network providers • Display costs with estimated cost of visit and treatment • Cost of insurance plans after subsidies • Provides quality ratings for each carrier • Allows users to enter prescription drug used to determine costs after insurance *Note:* iOS/Apple & Android mobile apps not available to users

Site Recommendations

Healthcaretransparency.org recommends eight key best practices for creating and maintaining a health care transparency tool. In summary, the recommended best practices include:

1. **Ease of Use and Innovative Features** – Invest in responsive web design, search engine optimization and content creation to produce a user-friendly platform.
2. **Consumer and Provider-Specific Information** – Information should be available at the individual provider level with cost estimates where possible.
3. **Cost Data** – Data should provide an estimated total price and out-of-pocket amount where possible.
4. **Quality data** – Data should be based on patient-centeredness, effectiveness, and safety of procedure.
5. **Represent Value** – Present cost and quality side-by-side to inform consumers that higher prices do not always indicate higher quality.
6. **In-Network and Out-of-Network** – Include both in-network and out-of-network cost and quality information (consumers identified this as one of the most important features).
7. **Health Insurance** – Insurer sites should show the cost of a plan, include a comparison of quality, benefits, and costs across plan options, and filter by those that are compatible with a Health Savings Account (HSA).
8. **Building an Audience** – Transparency tools have low utilization rates; educating and engaging consumers through public outreach, content generation and coordination are necessary.

2.2 Stakeholder Engagement

To gather stakeholder input, the GMCB consulted with interested stakeholders and members of the GMCB General Advisory Committee to assist in examining health care price transparency initiatives in other states through healthcaretransparency.org. After examining this site and transparency tools in other states, we asked stakeholders to provide feedback through a web form. The participants had 20

[29] Covered California: https://www.coveredca.com/
[30] MNSure: https://www.mnsure.org/

days to respond to the web form and in total, we received four responses out of the 40 stakeholders to our proposed question:

> *Based on your examination of health care transparency initiatives in other states, what features would you like to see available to health care consumers in Vermont?*

We asked only one question, hoping to increase the number responses, since the task of examining transparency tools is time-consuming. The feedback gathered came from individuals related to the health care system with administrative, provider, and consumer expertise.

Section 3. Results of Examining Health Care Price Transparency Initiatives

3.1 Transparency Tools

Based on our research of health care price transparency tools, we have outlined best practices associated with how to display cost and quality data to provide users with a practical and comprehensive transparency tool:

Cost & Quality

Price transparency tools should focus on providing a platform to help consumers make meaningful price comparisons. Any cost information provided should be recent and derived from the appropriate corresponding entity (i.e. payment data from recent insurance commercial claims). Health care service and provider prices should display both in-network and out-of-network prices, along with a patients' out-of-pocket (OOP) cost, deductible, copay, and coinsurance information. The website should also include an explanation of methodology so consumers can find out what elements created the cost information. Insurance carrier websites should include the cost of a specific plan after subsidies. Overall, cost information should be written simply to provide clarity.

Cost and quality information displayed side-by-side helps educate consumers that higher cost does not necessarily mean higher quality care. Transparency tools should report clinical quality of care information that are clearly explained. Just like cost data, the quality methodology should describe how the data were generated and when it was last updated. For health insurance shopping sites, quality ratings should also be included for each carrier.

Additional Tools

The transparency tool websites with the most features shared some other common tools, including:

1. Look up and search by hospital, provider, quality, price, or prescription drug;
2. Online sign-up for prescription drug price alerts, savings, and price recheck;
3. Coupons and discount cards for drug pricing sites, and;
4. Displayed payment bundled prices on physician sites for certain procedures, encouraging cost-effective care.

3.2 Stakeholder Feedback

Although the feedback we received from Vermont stakeholders was limited, the submitted responses did have some commonalities. The stakeholder input highlighted site design and comprehensive data as the most important items to include. The feedback received included:

- **Health care transparency tools should be designed to cater to health care consumers**. Overall, the site design should be simple and user-friendly to increase utilization. Users should be able to

look-up or search for a health care service by location, price, quality, and availability and include all pricing information dependent on the insurance plan (deductible, copay, OOP cost, etc.). Including an explanation of prices would also help consumers understand what they are paying for.

- **Comprehensive quality and cost data should be integrated and clearly explained.** List price, insurance coverage, copay, and deductible information should be included alongside quality information of a provider. Integration with electronic health records (EHR) would allow the provider to know cost and quality information in real-time when referring a patient. Sites should also include disclaimers explaining the cost displayed may not reflect the true cost paid by the patient.
- **A health care transparency tool should consider Vermont's health care reform efforts and state-specific limitations.** Through OneCare Vermont, the Accountable Care Organization, Vermont is moving away from fee-for-service (FFS) to a value-based payment system, which one stakeholder noted as a potential impact on the cost component of price transparency initiatives. Claims and payments will continue under a value-based payment system and would not impact a transparency tool's effectiveness. Also, users may not be able to access the "best" or "lowest cost" providers or services, especially if a doctor is not accepting patients or the facility location is too far.

Section 4. Next steps: Options in Health Care Pricing Information

Although Act 53 does not require the GMCB to provide recommendations, we included potential next steps for the legislature to consider. Based off prior research, stakeholder engagement, and our examination of transparency tools in other states, we present the following considerations to help guide Vermont should it decide to further explore creating a price transparency tool:

1. **Conduct a needs assessment**. Research and work with stakeholders to assess the feasibility and value of implementing a transparency tool website.
2. **Define goals and objectives.** Clearly outline the goals and objectives for the site.
3. **Evaluate funding and resources**. Find a reliable and consistent funding source and create a financially sustainable option.
4. **Select website features.** Decide what data to incorporate on the health care transparency tool website (price, quality, prescription drug prices, etc.).
5. **Implement best practices**. To increase utilization and usefulness, be sure to include the best practices featured on the other sites and preferences outlined by the stakeholders.

Part B. Coordinated Billing Processes

Section 1. Background

Act 53 of 2019, Sec. 3 (b) tasked the Green Mountain Care Board, in consultation with interested stakeholders, to "consider and provide recommendations regarding potential financial procedures for health care services that would coordinate processes between hospitals and payers without requiring the patient's involvement and would provide patients who receive hospital services with a single, comprehensive bill that reflects the patient's entire, actual financial obligation."

Health care billing is a three-party system involving a patient, health care provider and an insurance company, or payer. After a patient receives care, a provider compiles the information into a bill and files

it as a claim to the insurer. A bill, which outlines all the provider's charges, does not represent the full cost to the payer. The actual level of reimbursement is dependent on many variables, but not limited to member eligibility, member cost share, and the provider's contract with the payer. The provider is responsible for ensuring the claim meets standards of compliance and reviews the codes to ensure the procedures are billable.

Once the claim reaches the payer, the adjudication process begins. Adjudication means the payer evaluates the medical claim and decides if it is valid and how much of the claim the payer will reimburse[31]. The payer usually has a contract with the provider that stipulates reimbursement rates for procedures. A remittance advice or payment voucher is sent to the provider or biller detailing line by line reimbursement. If there are any discrepancies, the provider submits a corrected claim or will appeal the payment with the payer. Any remaining balance on the claim is then applied to the member's cost share responsibilities. This is communicated to the member on an Explanation of Benefits (EOB) with the statement describing what benefits and coverage the patient receives. Providers follow up with patients when payment is late or not received in full.

Section 2. Description of Assessment

This section provides the specifics of our research regarding potential financial procedures for health care services that would coordinate processes between hospitals and payers. Our research included:

- Stakeholder engagement
- Evaluation of private sector billing services

2.1 Stakeholder Engagement

The stakeholder engagement we conducted focused on gathering potential best practices for creating a simplified billing system between hospitals and payers in Vermont. We consulted with members from state and national agencies including; Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care (MVP), Vermont Medical Society (VMS), Vermont Association for Hospitals and Health Systems (VAHHS), Department of Vermont Health Access (DVHA), Vermont Program for Quality in Health Care (VPQHC), Health Care Advocate (HCA), National Association of Health Data Organizations (NAHDO), and the All-Payer Claims Database (APCD) Council. During the stakeholder meeting, we asked members to focus on the 5 questions proposed below regarding coordinated billing in Vermont:

1. What are the challenges and concerns you have from your perspective with coordination of billing?
2. What are some potential areas of improvement that could be explored and shared?
3. The legislation calls for GMCB to provide recommendations for potential financial procedures in the health care system that would be easier to coordinate billing between hospitals and payers. What are some examples that come to mind?
4. What will it take to move the Vermont health care system toward single, comprehensive billing?
5. What resources exist to help support this work?

[31] Medical Billing & Coding Certification. "3.03: The Medical Billing Process." https://www.medicalbillingandcoding.org/billing-process/

2.2 Evaluation of Private Sector Websites

For further research, the stakeholders suggested examining existing companies that provide simplified billing services. We examined two major companies – Health Payment Systems (HPS) and OODA Health (OODA) – offering a billing service with convenient payment options.

Health Payment Systems (HPS)

HPS is a HIPPA compliant company available to insurance brokers, employers, providers, individuals and families and third-party administrators (TPAs) offering two main services:

Independent Provider Network: Based in Eastern Wisconsin, HPS offers an independent provider network and has contracted with providers in two-thirds of Wisconsin counties. The network does not provide care directly to patients, members have access to the services offered by HPS. On behalf of the network, HPS takes responsibility for patient billing and collection, removing it from the provider, and in the past 10 years, has assumed responsibility for over $240 million in patient debt. The HPS network consists of 96 hospital facilities and 22,600 individual providers with 94.6% of their members utilizing the service[32]. HPS also offers cost-saving solutions to their clients such as telemedicine and bundled payments for common procedures. With their provider directory, patients can also find out if a doctor is part of the HPS network.

Simple Billing & Payment Experience for Consumers: If an individual's or family's health plan participates with HPS or a patient receives care from a provider participating in HPS, the patient has access to a "SuperEOB". A SuperEOB is a statement that consolidates an individual's or family's in-network explanation of benefits (EOBs) and medical bills for an entire month. The SuperEOB is like a credit card statement, clearly outlining what is owed only by the patient. The HPS member portal allows members to pay online and access details about their claims. Interest-free payment plans are available and HPS coordinates with secondary insurance, bankruptcy and charity care with providers on a member's behalf if necessary. HPS commits to meet or exceed payment turnaround time within 20 business days, averaging 14.7 days for full payment in 2018.

HPS makes money in two ways. First, HPS contracts with health systems, physician practices and other providers to pay a medical bill of a patient in an employer's health plan promptly and in full, including the deductible. This spares the health system and other providers from the expense of sending out multiple bills and reduces bad debt from unpaid bills. HPS receives a fee or discount on the amount owed. Second, HPS receives a fee from a participating employer and HPS assumes the risk that the employee will pay the deductible[33].

OODA Health

OODA Health is a San Francisco based startup working with payers and providers to redesign the health care billing and claims payment system. OODA pulls clinical data from electronic health records (EHR) to help insurers pay for health care services in real-time[34]. Providers are paid upfront and paid a

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[32] Health Payment Systems (HPS): https://www.hps.md/the-hps-network/

[33] Boulton, Guy (2017). HPS unites, simplifies patients' medical bills, *Milwaukee Journal Sentinel*, Published April 29, 2017: https://www.jsonline.com/story/money/business/health-care/2017/04/29/hps-unites-simplifies-patients-medical-bills/100741212/

[34] Truong, Kevin (2018). OODA Health gets $40.5M Series A round to remake healthcare payments, *Med City News*, Published September 2018: https://medcitynews.com/2018/09/ooda-health-gets-40-5m-series-a-round-to-remake-healthcare-payments/

guaranteed rate based on their historical collection rate that is adjusted over time[35]. In the end, the payer would be responsible for collecting any outstanding payments from the member instead of the provider. Payers own the member financial experience and can design new products, sell concierge billing services, and offer financing for elective care. With OODA, providers and payers can see a reduction of administrative cost and efforts.

OODA Health offers **OODAPay**, which is a cloud-based healthcare payment platform. Patients of participating providers will be able to access OODAPay online to view, understand, and pay their balance. Zero percent interest payment plans are available, and users can choose the term length. OODA makes money by charging a fee for its services and risk-sharing payment model. Currently, OODA works with Anthem, CommonSpirit Health, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Arizona, and Blue Shield of California[36].

Section 3. Results

3.1 Stakeholder Engagement

Input from stakeholders reflects the complexity of the health care billing and payment structure in the United States. The group focused on how to move Vermont to a coordinated billing system by outlining the main challenges and concerns before providing recommendations.

Challenges and Concerns

The stakeholders collectively agreed on the challenges and concerns related to creating a coordinated billing system in Vermont.

- **Cost & Risk:** Either the state or an outside company would be required to take on the risk and associated cost to create and maintain a coordinate billing system between hospitals and payers.
- **Outside Factors:** Out-of-state carriers, Medicare and other federal entitlement programs would make it difficult for patients to receive a single, comprehensive bill.
- **Information Technology:** The technology to support a coordinate billing system across Vermont providers may need improvement. Vermont hospitals and other providers may require a legacy system update to effectively submit charges on a coordinate billing system, which would be an additional cost.

Considerations

The stakeholders outlined potential areas of the Vermont health care system that coordinated billing could potentially improve upon.

- **Administrative Burden:** At the GMCB, we consistently hear that the growing number of administrative duties imposed on physicians is burdensome. The tasks range from federal and state requirements to payers, vendors, and suppliers. The stakeholders noted a coordinated billing system would potentially decrease administrative burden, especially for smaller practices and independent doctors in Vermont.
- **Payment Options:** Ideally, a coordinated billing system would be compatible with Flexible Spending Accounts (FSA) and Health Reimbursement Arrangements (HRA) as well as Charity

[35] OODA Health. "Introducing OODAPay™": https://www.ooda-health.com/oodapay
[36] OODA Health: https://www.ooda-health.com/

Care. Without this integration, consumers would be less likely to benefit from a coordinated billing system.

Stakeholder Recommendations

The two main recommendations made by the stakeholder group included:

1) **Address timing of billing between provider and payer:** According to the state stakeholders, billing of services happens within 60 days after a procedure. The stakeholders recommend providers make a financial claim within a shorter timeframe to avoid bill delays and confusion among patients. Providers could also implement facility-specific consolidated billing which covers the entire bundle of care a patient received into one statement. However, late charges and internal audits could impact a coordinated billing system.
2) **Continued research:** The stakeholder group *strongly* recommends the continuation of research and stakeholder input before moving forward with Vermont-specific recommendations. With limited research and information, it is unclear what it would entirely take to create and maintain a coordinated billing system in Vermont.

3.2 Assessment of Private Sector Websites

Although we attempted to more fully understand their business models, it was difficult to gather information regarding how the two companies we researched (HPS and OODA) operate on a granular level. However, the services offered by these private sector companies seem to address most of the difficulties of developing and maintaining a coordinated billing system. Based on our research, we compiled a list of best practices when developing a coordinated billing system:

1. **User-Friendly Platform Design:** To increase utilization and membership, platforms should be comprehensible to all users. HPS and OODA's websites and coordinated billing platforms are well designed, simple, and aesthetically pleasing.
2. **Clearly Describe Benefits**: Both companies clearly explain the member-service benefits for providers, payers, and patients.
3. **Outline Service Fees**: To find out costs and fees, providers and payers must inquire with the company. Potential members can request a demo from OODA to learn more but neither website has the information readily available.

Section 4. Recommendations for a Vermont Coordinated Billing System

Vermont should take into consideration whether creating a coordinated billing system is feasible and aligns with the state's current goals of health care reform. The most important consideration in Vermont is resources. Building and maintaining a state-based coordinated billing system would be a large expense for Vermont. The alternative is for Vermont to work with a private sector company. This option allows the state to avoid the cost of implementing and staffing a coordinated billing system altogether. If Vermont were to create a coordinated billing system, it would be ideal to make a product similar to the HPS SuperEOB. Providing patients with a comprehensive bill each month would be a user-friendly solution to the current billing system. However, there are some downsides. Both of the private sector companies we reviewed make money from fee charges, which would ultimately be passed onto the provider and onto the commercially insured patient in the form of increased provider rates, which may increase premiums. However, these charges might be more than offset by the reduced administrative

costs providers incur in the collections process. Additionally, private companies may be less transparent compared to state-based systems which may concern Vermonters.

Stakeholder input was essential to affirm how multifaceted and extensive the health care billing system is. **The GMCB agrees with stakeholders that Vermont should continue research and engagement to establish a baseline of knowledge before moving forward.** We also support learning more about the timing of billing between a provider and payer to assess whether establishing a shorter timeframe would help patients receive bills earlier to avoid confusion. Learning more about the payment system between Vermont payers and providers, both in-state and out-of-state, may present options to improve upon the current system.

Vermont should consider the recommendations below before deciding how to move forward on a coordinated billing system:

1. **Conduct a comprehensive needs assessment.** Assess the feasibility and potential value of creating a coordinated billing system by consulting with stakeholders and continuing research.
2. **Ensure that adequate funding and resources are available.** Vermont should determine if the state can successfully create and maintain a coordinated billing system, or a private company.
3. **Implement best practices**. Include best practices regarding comprehensive statements and setup of the private sector companies' coordinated billing systems.