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North Carolina Faces Hospital Fight Trying New Tack to Set Health-Care Payments; State wants to peg rates to what Medicare pays, but hospitals worry about the ripple effects

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North Carolina wants to reshape how it pays for its workers' health care—and save hundreds of millions of dollars—by scrapping the secret negotiations typically used to set rates with doctors and hospitals.

The fate of the plan, from the state's treasurer, is expected to be watched closely by other employers eager to stem rising health costs. But hospitals are already fighting back.

At issue is the system that employers' health plans have long used to determine how much they will pay doctors and hospitals. The payments are typically set through negotiations, conducted in secret, between health insurers and the hospital systems and physician groups.

Under the current system, rising health-care prices are the major driver of increases in the cost of employer health coverage, according to employers and researchers. With its new proposal announced last month, North Carolina likely became the largest employer to date seeking to try a new tack, health-insurance experts say.

The state's employee health plan, which covers around 727,000 people including teachers, university workers and state police, wants to pay hospitals and doctors rates pegged to how much the federal Medicare insurance program for the elderly pays for medical services.

The office of state Treasurer Dale R. Folwell, which oversees the plan, said the new rates would average around 177% of Medicare's fees, down from a current average of 213%. Such rates would save the state around $300 million a year and workers an additional approximately $66 million annually, Mr. Folwell's office said.

The state's employee health plan has an annual budget of around $3.3 billion.

"We're trying to fix something that's unsustainable," said Mr. Folwell. He said the plan's major goal is to make health-care pricing clear and public. "The customer has no idea what the payer is paying."

The treasurer wants to put the plan into effect in 2020. But hospitals in the state are already gearing up to oppose the effort.

Julie Henry, a spokeswoman for the North Carolina Healthcare Association, which represents hospitals, said some believe the proposed rates wouldn't be sustainable for them, and the financial impact could be "devastating" for about 20 hospitals that are operating on negative margins.

Hospitals are also concerned other employers and insurers would demand similar rates, Ms. Henry said.

"This kind of change, and the ripple effects that might come from that, put hospitals and access to care at risk," Ms. Henry said. She said hospital officials are speaking to state legislators "to determine what is a potential course of action they might look at to encourage a more workable solution."

Officials with the North Carolina Department of State Treasurer said they sought to set fair prices, including amounts they said could represent an average increase for independent primary-care doctors and some rural hospitals.

Mr. Folwell, a Republican, is elected by voters in the state, not appointed by lawmakers or the governor.

The North Carolina proposal will be closely watched by other states and government and private employers, health-care experts say, because it takes direct aim at the prices paid for health care in an effort to rein in spending.

Research from the nonprofit Health Care Cost Institute has pointed to the price of health care as the primary driver of the rising cost of employer coverage, rather than increasing use of services.

"All purchasers, public and private, face the same pressures," said Robert Galvin, chief executive of Equity Healthcare, which negotiates contracts with health insurers and manages health-care costs on behalf of companies owned by big private-equity firms including Blackstone Group, where he is an operating partner. "There's going to be a lot to learn, to see how it goes."

The effort faces serious challenges because of hospitals' clout. In some parts of North Carolina, big systems of hospitals have large market share, while small towns may have only one hospital. The state may find it difficult to assemble a network of hospitals across the state willing to take its rates.

If hospitals refuse to accept the rates that Mr. Folwell wants, the state plan says it will simply not include them in its network of providers. Yet that could leave workers who use those hospitals exposed to huge bills, because hospitals might demand they pay full charges, without the discounts that insurers typically negotiate.

Mr. Folwell said he is "keenly aware" of the impact of out-of-network billing on consumers, and it is too soon to tell how the issue will play out. The State Employees Association of North Carolina, a union representing state workers, has said it supports the plan.

"The state of North Carolina, the treasurer, is sending a powerful signal, but it will be hard to implement," said Jeff Levin-Scherz, a leader of the health management practice at Willis Towers Watson. "The danger is if they don't sign on the dotted line."

At least one other state, Montana, has implemented a plan similar to the North Carolina proposal.

Getting hospitals to accept its rates, which were set at around 230% to 240% of Medicare's, "definitely was a game of chicken," said Amy Jenks, the acting administrator who oversees the state's employee health plan, which covers around 30,000 people.

One hospital was still holding out when the plan launched in July 2016, with the state initially offering to pay travel expenses for workers to get to alternative hospitals, Ms. Jenks said. The holdout hospital agreed to join a few weeks later.

Ms. Jenks said the shift to Medicare-linked pricing has saved the state about $10 million over the two years it has been in place, leaving overall spending of $260 million over that span. Health plans covering Montana municipal and county employees have implemented similar setups, she said.

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