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Health plans for state employees use Medicare's hammer on hospital bills

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States. They're just as perplexed as the rest of us over the ever-rising cost of healthcare premiums.

Now some states are moving to control costs of state employee health plans. And it's triggering alarm from the hospital industry. The strategy: Use Medicare reimbursement rates to recalibrate how they pay hospitals. If the gamble pays off, more private-sector employers could start doing the same thing.

"Government workers will get it first, then everyone else will see the savings and demand it," said Glenn Melnick, a hospital finance expert and professor at the University of Southern California. "This is the camel's nose. It will just grow and grow."

In North Carolina, for instance, state Treasurer Dale Folwell next year plans to start paying hospitals Medicare rates plus 82%, a figure he said would provide for a modest profit margin while saving the state more than $258 million annually.

"State workers can't afford the family premium [and other costs]. That's what I'm trying to fix," he said. The estimated $60 million in savings to health plan members, he said, would mainly come from savings in out-of-pocket costs.

That approach differs from the traditional method of behind-the-scenes negotiating, in which employers or insurers ask for discounts off hospital-set charges that rise every year and generally are many times the actual cost of a service. Private-insurer payments, even with those discounts, can be double or triple what Medicare would pay.

This state-level activity could be a game changer, fueling a broad movement toward lower hospital payments. Montana's state employee program made the adjustment two years ago; Oregon will start this fall. Delaware's state employee program is also considering such "Medicare-based contracting" as one of several options to lower spending.

The bold move comes as other factors — notably marketplace competition among hospitals and high-deductible insurance plans aimed at getting consumers to "shop" for lower prices — have largely failed to slow rising healthcare premiums.

For hospitals, though, it can be viewed as "an existential threat," said USC's Melnick.

Indeed, the treasurer's plan in North Carolina has drawn heated opposition, with a hospital industry-associated group running television ads warning of dire consequences, especially for rural hospitals, some of which they say might be forced to close. When the plan first came out, the state's hospital associationcomplained it would reduce statewide hospital revenue by an estimated $460 million.

Hospitals in areas with large concentrations of state workers "would be getting reimbursed less than the cost of care," said Cody Hand, the association's senior vice president and deputy general counsel. "Our biggest concern is this is not something that we were at the table for in discussion."

Rural hospitals are particularly at risk, Hand said, because many were already teetering on the brink financially and the payment change would be an additional problem.

After months of acrimony, the North Carolina treasurer in mid-March agreed to grant a 20% boost in payment to rural hospitals that would give those hospitals an additional $52 million a year. On average, rural hospitals would be paid 218% of the Medicare rate.

Nationwide, hospitals have long complained that Medicare underpays them, and some hospital and business groups have warned employers that tying payments from state workers' plans more closely to Medicare could result in higher charges to private-sector businesses.

"The result will be a cost shift of tens of millions of dollars to other Oregonians," wrote the Oregon Association of Hospitals and Health Systems as lawmakers there debated a plan (that eventually became law) paying hospitals 200% of Medicare rates.

But policy experts are skeptical.

"Even if Medicare pays a bit below cost, 177% of Medicare should be at least 50% above cost," said Mark Hall, director of the health law and policy program at Wake Forest University. "Is that a reasonable margin? I guess that's up for debate, but to most people 50% margin might sound reasonable."

Another concern some people have raised is that hospitals might refuse to join networks that employ these states' Medicare-based strategy.

Indeed, Montana officials worked hard to get all hospitals in the state to agree to accept for the state worker program an average of 234% of Medicare's reimbursement rates. A few hospitals held out, right up to the deadline, backing down only after pressure from employee unions.

The risk if hospitals opt to remain out-of-network is that workers could be "balance billed" for the difference between those Medicare-plus rates and their generally much higher charges, amounts that could be hundreds or even thousands of dollars.

To prevent that, Oregon lawmakers set the law's in-network reimbursement for hospitals at 200% of Medicare. But those that opt out would receive only 185%.

The measure also bars hospitals from billing state workers for the difference between those amounts and the higher rates they might like to charge.

"Oregon thought it through," said Gerard Anderson, a professor at Johns Hopkins who researches healthcare costs. "Hospitals need to go on a diet. The private sector has not put them on a diet, but maybe the state employee plans will."

And in the private sector …

For decades, health insurance costs for employers and workers have risen faster than inflation despite various efforts to rein them in.

Currently, a typical family plan offered by employers tops $19,000 a year in premiums, while the price tag for a single employee is close to $7,000.

To be sure, hospital costs make up just one part of what premiums cover, along with doctor costs, drug payments and other services. Spending on hospital care accounts for about one-third of the nation's $3.5 trillion healthcare tab.

"Healthcare is just becoming unaffordable," said Cheryl DeMars, president and CEO of The Alliance, a group of 240 private-sector, self-insured employers that directly contract with hospitals in Wisconsin, northern Illinois and eastern Iowa.

In January, The Alliance began what it calls "Medicare-plus" contracting. As new hospitals join and existing contracts come up for renewal, the group is negotiating rates, basing them on what Medicare pays, DeMars said.

And it will likely save money: Under its old method of paying, the group was forking out between 200 to 350% of Medicare for inpatient and outpatient hospital services in its network. Two new contracts have been signed so far, averaging 200% of Medicare across inpatient, outpatient and physician payments, according to The Alliance.

"We want to pay a fair price and we're in the process of determining what that should be," said Kyle Monroe, vice president of network development for The Alliance. "Is it 200%? Is it something less?"

Under traditional payment methods, the negotiated prices insurers for public- and private-sector employers pay for hospital care vary widely, by facility, treatment and insurer. But they're generally above Medicare rates by a substantial margin.

A group of self-insured employers recently commissioned Rand Corp. to study what private insurers pay hospitals in 22 states, compared with Medicare rates.

Initial results found private employers were paying, on average, 229% of Medicare rates to hospitals across the states in 2017, according to Chapin White, an adjunct senior policy researcher at Rand who conducted the study.

Economists like Melnick say they would prefer that market competition — consumers voting with their feet, so to speak — would drive business to the highest-quality, lowest-cost providers.

But, so far, hospitals have held the line against this scenario and that's not likely to change. "They're going to fight like crazy," Melnick said.

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