aware of the state protections and submit a substantial amount of paperwork to get redress.

Ultimately, surprise out-of-network billing is the result of a market failure: the lack of a competitively set price for physician services. There are various ways such a price could be established. We believe the best solution would be for states to require hospitals to sell a bundled ED care package that includes both facility and professional fees. In practice, that would mean that the hospital would negotiate prices for physician services with insurers and then apply these negotiated rates for certain designated specialties. The hospital would then be the buyer of physician services and the seller of combined physician and facility services. If physicians considered the hospital's payment rates too low, they could choose to work at another hospital.

This solution preserves price competition. Emergency physicians would compete on price and quality to offer services to hospitals. Hospitals would compete on the price and quality of their package of emergency services to be included in insurers' networks. Hospitals would also compete to offer sufficiently high rates to attract physicians. Insurers would compete on premiums and quality to attract employers and enrollees but would increase provider payments to create attractive networks. Most crucially, patients would always be protected.

Disclosure forms provided by the authors are available at NEJM.org.

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Adding Value by Talking More

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The prevailing fee-for-service payment model has led U.S. health care administrators and physician practices to impose severe constraints on the time physicians spend talking, for which they are reimbursed poorly or not at all. New value-based reimbursement models, however, such as bundled payments, accountable care organizations, and shared savings plans, provide powerful incentives for physicians to regain control over the quantity and quality of time they spend talking. As we have helped dozens of organizations to estimate total care-cycle costs, we've identified many situations in which having physicians and other clinical personnel talk more with patients and each other can be the least expensive and most effective approach for delivering better patient care.

One important role of physicians' talking is to motivate patients to make earlier and better decisions about their care. Less than half of patients with chronic kidney disease, for example, currently prepare effectively to start dialysis. Ideally, a vascular surgeon should place a fistula or graft several months before the start of hemodialysis. But nephrologists, under pressure to maximize the number of patients they see per day, often lack sufficient time to persuade patients to start dialysis with a matured fistula or graft — a conversation that we calculate costs less than $200. The consequence is that too many patients begin dialysis with a catheter and subsequently have high rates of infections and other complications that not only harm them but also increase treatment costs during the next 6 months by more than $20,000.[1]

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