This policy did not overcome long odds in the legislature, and similar policies might not succeed in other states without federal financial participation, which is currently illegal.

Any state policy action on this front will take place in the face of an uncertain future for providing undocumented immigrants with a path to permanent residence or citizenship. In addition to the hostile national political climate, the recent Supreme Court split over Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) in *U.S. v. Texas* leaves in place a nationwide injunction against granting recognition to undocumented-immigrant parents in mixed-status families. This stalemate could even indicate a shift in sentiment against undocumented-immigrant children, since it also keeps President Obama's immigration policy known as Deferred Action for Childhood Arrivals (DACA), which grants nonimmigrant legal status to undocumented-immigrant children who entered the country before 2007, from being extended to include all children who arrived in the country before 2010. The continuing uncertainty regarding the future of DACA and DAPA may make it more difficult for states such as California to develop programs that effectively provide services to undocumented immigrants, because it perpetuates the chilling effect associated with children's unauthorized status. Furthermore, even if the Court had not suspended the administration's executive actions, existing federal restrictions on access to public programs for undocumented immigrants continue to necessitate state-based solutions to coverage.

An audio interview with Ms. Fabi is available at NEJM.org

In this challenging environment, the California legislature's move to cover undocumented-immigrant children through Medi-Cal and include undocumented-immigrant adults in the insurance exchange can provide important test cases for legislation that could be replicated in other states. Building a coalition to support and sustain these programs, which rely on uncertain state revenues, will be an important further test going forward. The improving state economy, coupled with reduced spending on care for indigent citizens now covered by Medi-Cal under the ACA, creates an unusual window of opportunity for these actions. California has the opportunity to point the way forward.

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

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1. Artiga S, Damico A, Young K, Cornachione E, Garfield R. Health coverage and care for immigrants. Washington, DC: Kaiser Family Foundation, January 20, 2016 (http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants).
2. Saloner B, Koyawala N, Kenney GM. Coverage for low-income immigrant children increased 24.5 percent in states that expanded CHIPRA eligibility. Health Aff (Millwood) 2014;33:832-9.
3. Wallace SP, Torres J, Sadegh-Nobari T, Pourat N, Brown ER. Undocumented immigrants and health care reform. Los Angeles: UCLA Center for Health Policy Research, August 31, 2012 (http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf).
4. Ponce N, Lavarreda SA, Cabezas L. The impact of health care reform on California's children in immigrant families. Policy Brief UCLA Cent Health Policy Res 2011;June:1-6.
5. Health insurance companies and plan rates for 2016: keeping the individual market in California affordable. Covered California. October 29, 2015 (http://www.coveredca.com/pdfs/7-27-coveredca-2016planrates-prelim.pdf).

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Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise

Zack Cooper, Ph.D., and Fiona Scott Morton, Ph.D.

Although the Affordable Care Act has increased the number of Americans with health insurance, a 2014 survey found that 20% of insured people still have trouble paying medical bills.[1] A major source of financial hardship for patients comes from surprise bills from physicians who are not in their insurance network. Recent media reports have described large and troubling surprise bills from anesthesiologists, radiologists, and surgeons who assisted during routine procedures.[2] Surprise bills from emergency physicians have also been a source of concern and are representative of the wider problem.

U.S. hospitals generally contract with physician groups to

provide care in their emergency departments (EDs). Emergency physicians, however, contract independently with insurance companies, and they and the hospitals where they work may not contract with the same insurers. As a result, patients who choose an in-network ED may discover later that the physician who treated them wasn't in their insurer's network. The result is a large physician bill that the insurer doesn't cover or only partially covers, leaving the patient to pay the balance.

Surprise out-of-network billing is problematic for two reasons. It prevents health care markets from functioning as they should. And the bills can amount to thousands of dollars.

In most areas of health care, physicians compete to be included in insurers' networks on the basis of price and quality. If an insurer offers undesirably low reimbursement rates, however, physicians may refuse to contract with that payer and enter an alternative insurer's network or decide to care for cash-paying patients exclusively. Insurers compete by reducing premiums to attract employers and on various dimensions of plan quality, such as the breadth of their network. If an insurer cannot develop an adequate network of well-regarded physicians, patients will opt for coverage from rival insurers.

Surprise out-of-network billing is problematic for two reasons. First, it prevents health care markets from functioning as they should. Consumers don't choose out-of-network emergency physicians and aren't informed of out-of-pocket prices before receiving care. For emergency care, rather than selecting an individual physician, patients choose an "emergency package" that includes care from both a physician and an ED. Because patients don't have a choice of emergency physicians and cannot avoid out-of-network doctors at in-network facilities, emergency physicians will get the same amount of business regardless of their prices or their participation in insurance networks. As a result, absent intervention, emergency physicians can sidestep the price competition that other physicians face when treating privately insured patients.

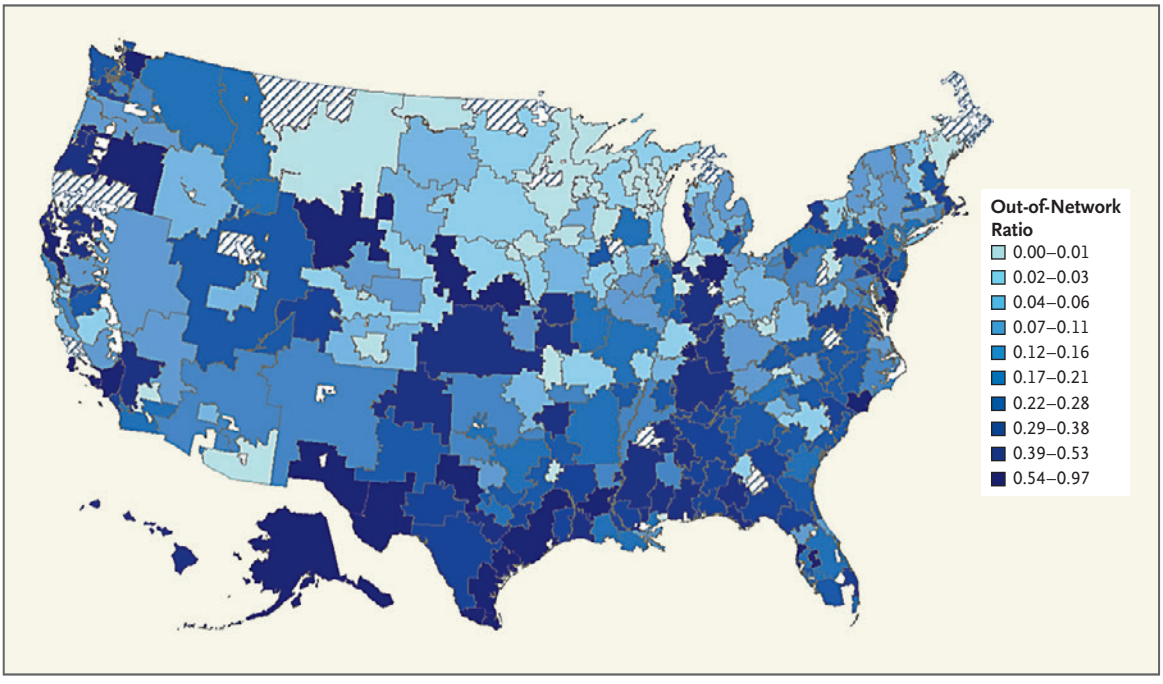
Second, surprise out-of-network bills can amount to thousands of dollars. The Federal Reserve found that 47% of Americans couldn't cover an unexpected $400 expense without selling assets or borrowing money.[3] Most patients select in-network EDs for emergency care. They should rightly expect to be treated by in-network doctors and shouldn't face financial ruin as a result of physician bills they cannot reasonably avoid.

We are not aware of any studies of the prevalence of surprise billing by emergency physicians on a national level. To our knowledge, Texas is the only state that has gathered data on this topic. Among the hospitals included in the networks of the three largest payers in Texas, 21 to 56% have no in-network emergency physicians.[4]

To determine the scope of this problem nationwide, we analyzed claims data from a large commercial insurer that covers tens of millions of people. We focused on ED visits for people under 65 years of age that occurred between January 2014 and September 2015 at hospitals registered with the American Hospital Association. We identified the hospital referral region (HRR) in which the visit occurred, limiting our analysis to HRRs with 500 or more ED visits during the target period. Applying these criteria yielded data on more than 2.2 million ED visits in 294 of the 306 HRRs, covering all 50 states and capturing more than $7 billion in spending.

Our results are deeply troubling: of the 99.35% of ED visits that occurred at in-network facilities, 22% involved out-of-network physicians. This figure masks significant geographic variation in surprise-billing rates among HRRs. In McAllen, Texas, and St. Petersburg, Florida, surprise-billing rates were 89% and 62%, respectively (see map). In contrast, in Boulder, Colorado, and South Bend, Indiana, the surprise-billing rate was near zero, suggesting that surprise billing is a solvable problem.

Because our data do not cover markets uniformly across HRRs, we compared the rate of out-of-network billing we observed in areas where our data capture a higher share of the privately insured population with those where they capture a lower share. Using insurance-enrollment data from



Proportion of ED Visits at In-Network Facilities Involving Out-of-Network Physicians, by Hospital Referral Region.

HealthLeaders InterStudy (a health care business information company), we calculated the proportion of each HRR's total privately insured population that is covered by our data. We then analyzed the rate of out-of-network surprise billing by emergency physicians for HRRs in the top and bottom quartiles of market coverage. The mean rate of surprise billing was 18.6% in the former and 24.4% in the latter. The correlation between the share of the population covered per HRR and the rate of out-of-network billing is −0.11.

We also estimated the potential extra cost for patients who are treated by an out-of-network emergency physician. On average, in-network emergency-physician claims were paid at 297% of Medicare rates. For reference, orthopedists in our data set were paid at 178.6% of Medicare rates for knee replacements, and internists were paid at 158.5% of Medicare rates for routine office visits. Our data show that out-of-network emergency physicians charged an average of 798% of Medicare rates. We calculated the potential additional cost for patients as the difference between the out-of-network emergency-physician charge and 297% of the Medicare rate for the same services in the patient's location and found that patients could be billed for an average balance of $622.55 (unless their insurer paid the difference). It is also important to note that the potential balance bills can be extremely high; the maximum potential balance bill faced by a patient included in our data set was $19,603.30.

Perhaps because the scale of this problem has not been known, there are virtually no federal protections against surprise physician bills, and the response in most states has been inadequate.[5] A number of states have introduced "hold-harmless" provisions that prohibit out-of-network providers from balance billing patients.[5] However, these laws typically require the insurer to pay the full billed amount. Although they limit additional costs for consumers, such laws create perverse incentives for providers to avoid joining networks, because the insurer must still pay the billed rate. Insurers will ultimately pass these higher costs on to consumers in the form of higher premiums.

Some states, including New York, have adopted hold-harmless provisions together with a mediation process in which providers and payers negotiate payments for out-of-network services. Although New York's law is one of the most ambitious to date, it doesn't apply to people who receive insurance coverage from self-insured firms. Furthermore, patients who receive surprise bills must be

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.

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1. Hamel L, Norton M, Pollitz K, Levitt L, Claxton G, Brodie M. The burden of medical debt: results from the Kaiser Family Foundation/New York Times Medical Bills Survey. Menlo Park, CA: Kaiser Family Foundation, January 5, 2016 (http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/).
2. Rosenthal E. Costs can go up fast when E.R. is in network but doctors are not. New York Times. September 28, 2014 (http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?_r=0).
3. Board of Governors of the Federal Reserve System. Report on the economic well-being of U.S. households in 2015. Washington, DC: Federal Reserve, May 25, 2016 (http://www.federalreserve.gov/econresdata/2016-economic-well-being-of-us-households-in-2015-preface.htm).
4. Pogue S, Randall M. Surprise medical bills take advantage of Texans: little-known practice creates a "second emergency" for ER patients. Austin, TX: Center for Public Policy Priorities, September 15, 2014 (http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf).
5. Hoadley J, Ahn S, Lucia K. Balance billing: how are states protecting consumers from unexpected charges? Washington, DC: Georgetown University Health Policy Institute, June 2015 (http://www.rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html).

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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]