Episode 21 – Putting health care in employees' hands (MediBid)

[MUSIC PLAYING]

RALPH WEBER: When you're putting the request on MediBid, you have potentially thousands or tens of thousands of doctors that are looking at it. And you'll get an inherent built-in second opinion.

SPEAKER: Welcome to "The Cure for the Common Company," a podcast series looking at innovations in the world of employee health and well-being. Steve Blumenfeld and other experts from Willis Towers Watson's Health and Benefits Practice are talking to entrepreneurs and industry leaders who break ground to meet the needs of today's workforce and deliver benefit solutions that can separate employers from the pack.

STEVE BLUMENFIELD: Ralph, how you doing?

RALPH WEBER: I'm doing well, Steve. Thank you. Thank you for having me here today.

STEVE BLUMENFIELD: Thanks for being here today. Hi, everybody. This is Steve Blumenfield with Willis Towers Watson. Welcome to "The Cure for the Common Company." Today, we are joined by Ralph Weber. Ralph has created a solution called MediBid, a tool where transparency meets competition through bidding. Talking with me with Ralph today is my wonderful colleague Courtney Stubblefield. Courtney.

Hi, Steve. Yeah, thanks for having me. I'm glad to be on the podcast today with you. Nice to meet you, Ralph. I have spent a good deal of time--

RALPH WEBER: Nice to meet you, too.

COURTNEY STUBBLEFIELD: --working in the health care delivery space, so very interested to help us unpack the innovative delivery solution that MediBid brings.

STEVE BLUMENFIELD: All right, Courtney.

RALPH WEBER: It's good to be here.

STEVE BLUMENFIELD: Great. Let's get right down to it then. Tell us a little bit about what drove you to create MediBid.

RALPH WEBER: Well, Steve, my background is in employee benefits. But I had a couple of family medical needs that were unmet. We were living in Canada. And my wife at the time had been waiting 2 and 1/2 years for orthopedic surgery on a medical waiting list. And we just couldn't get the surgery. So we moved to the US. And we went around, and we got some bids on providing that care. Because we knew we would have to pay cash.

We got several hospitals to bid on it. And we looked at the quality. And then we chose the best one, got the whole surgery done for under $2,300. Then we realized that there really is a much larger need. We could help a lot more people than just ourselves. So that was a few years after the surgery where we started MediBid.

STEVE BLUMENFIELD: Well, fascinating. So you actually were struggling to get the care you needed took into your own hands figured out a better solution

RALPH WEBER: Correct, yes. And then at first we were marketing more to individuals, uninsured, high deductibles, et cetera, then we realized that there really was a good fit with the employer market, which was my background. We incorporated it in. And we learned a lot over the years, crafting a solution that really improves the quality while reducing costs.

STEVE BLUMENFIELD: Fantastic.

COURTNEY STUBBLEFIELD: So Ralph, this is Courtney. I think the idea that you came and applied, you know, normal business principles to the purchase of health care in the United States is pretty fascinating. As I'm sure you've come to learn, not how most health care is sourced today in our country.

So kind of picking on the area, the theme of fostering competition, can you talk a little bit about the bid platform, and how you affect that? How does the system and the program actually drive that competition if someone needs to secure a health care service?

RALPH WEBER: OK, Courtney, that's a great question. We call our physicians and hospitals, we call them bidders. And we call the patients seekers, seekers of medical care. So the seeker goes online and makes their request. They add any particulars. They can upload some documents. They answer a few health questions, describe their symptoms. And what they see, the first thing they see is they see three numbers.

Here's what Medicare approximately pays for this procedure. Here is the Healthcare Bluebook fair price for this procedure. And this is the average bid that has been made over the last six months. The bidder sees those same three numbers. So they see the median bid. And for example, for a knee replacement, right now our average bid on a knee replacement over the last three years has gone down from about $19,000 to $17,200.

So that competition has created a decrease in cost and an increase in quality. When they see the median bid, they're not going to bid $28,000, $30,000. They're going to want to be competitive. Because they're going to want to receive that incremental business. So some of the bids are received right away, where the bidders have preprogrammed their prices. And others are received within a day or two, when the bidders want to just review the notes and give either a second opinion or bid on that episode of care.

STEVE BLUMENFIELD: Fascinating. Hearing that, I'm putting myself in the shoes of the person seeking that care. What a different experience than anything I've ever been exposed to. Do you have any anecdotal reactions from folks to what that experience is like when they're really getting a sense of what the market is actually paying for these procedures?

RALPH WEBER: Yeah, absolutely. There was an episode just this year, probably January, a month and a half ago. We had a client where a young mother needed a fetal MRI, because she was in a high-risk pregnancy. She went to the local hospital, children's hospital, and was given an estimate of $2,200. We were informed about this need and we put it out on MediBid. And we got a bid from Dallas for $651.

So we called her up. And we said, we understand you're looking for fetal MRI. And she said, yeah, you know, we kind of decided not to do it. It's just after Christmas.

STEVE BLUMENFIELD: Wow.

RALPH WEBER: We've got big bills and haven't satisfied our deductible. So in a high-risk pregnancy, this could be a NICU claim. So I said, well, I've got good news. There is a bidder that has bid $651, which is within the plan allowable. So instead of having your deductible, we can do this for a $100 co-pay. And she was blown away. She said, wow, that's amazing.

You know, I wasn't going to do it because of the cost. But I think my OB/GYN probably suggested I do it for a reason. So let me go back and talk to him and see if I need this. So that's one story that comes to mind that's very recent.

COURTNEY STUBBLEFIELD: So you're really-- you're bringing transparency to the process in a way that just simply doesn't exist in general. So I'm sure, you know, that's very informative, educational for people. And they're getting these nice results. Can you talk a little bit about the quality side of the equation? So how does that play into the process?

RALPH WEBER: OK.

COURTNEY STUBBLEFIELD: And I don't know if the example you're giving has actually played out yet, to kind of talk about the outcome and the experience part of it. That is, of course, very important, right, to employers, really--

RALPH WEBER: Yes, absolutely.

COURTNEY STUBBLEFIELD: --any health care consumer in general.

RALPH WEBER: Sure.

COURTNEY STUBBLEFIELD: Yeah.

RALPH WEBER: Well, you know, what we found is that there is often an inverse correlation between cost and quality, the higher the cost, the lower the quality. And anecdotally, it's easy to explain when you compare two knee surgeons, an experienced one that does 500 procedures a year versus an inexperienced one that does one or two. Now the four main costs, besides the aspirins and Kleenex and all those other small costs, the four main components of a knee surgery are the surgeon's fee, the anesthesiologist, who bills by time, the OR room, operating room that bills by time, and nights in the hospital.

Now if the experienced surgeon can do that surgery in half an hour, minimal OR time, minimal anesthesia time, and they probably don't have to stay overnight in the hospital. And inexperienced surgeon that might take two hours to do the same procedure, you know, there's more OR time, more anesthesia time, and potentially one or two nights in the hospital. So it's actually more expensive.

We analyzed data from the state of Tennessee. And we looked at many procedures. Colonoscopy was a very interesting one. There were a lot of providers that charged in excess of $15,000. And CMS rated those as two stars out of five. The providers that were under $5,000 were rated five out of five. So that was based on $2.7 billion worth of claims, so it was a large sample.

STEVE BLUMENFIELD: So really that answer is saying that, looking across the population basis, there's the tendency to have that correlation. But it doesn't sound like, at this point, the tool has any specific quality measures on these doctors.

RALPH WEBER: We do. We do, Steve.

STEVE BLUMENFIELD: OK.

RALPH WEBER: When we first have a doctor that signs up, we use the regular commercial tools, Leapfrog, Healthgrades, Vitals, Rate My MD, things like that. We get our own patients to review the doctors. Some of

our clients want the CMS ratings as well. So we have a supplemental tool where we can pull those in as well. Those ratings, as you know, are good for hospitals by DRG but they're not necessarily great in terms of individual physicians yet.

STEVE BLUMENFIELD: That's the case for the entire transparency space as well, at large. Go ahead, Courtney.

RALPH WEBER: Right.

COURTNEY STUBBLEFIELD: Yeah, no, it made me wonder, Ralph, if you're including any kind of, you know, social media component for your seekers right after the fact. Are they able to report back or share their experience, whether it's a star rating or that kind of feature? Or is that something you might do going forward?

RALPH WEBER: Right. Well, that's a great idea Courtney. When do you want to start in my marketing department?

[LAUGHTER]

We do encourage them to rate their physicians and that goes on the physician's profile. You know, but it doesn't go out on Twitter or social media. So I'm going to have to make a note of that, because I love that idea.

COURTNEY STUBBLEFIELD: So--

RALPH WEBER: All right.

COURTNEY STUBBLEFIELD: --pivoting just a little bit, can we talk for a minute about the value proposition to the providers, right, who sign up? So I--

RALPH WEBER: Yes.

COURTNEY STUBBLEFIELD: --assume in conjunction with marketing this to seekers needing health care, it is also building out that benefit to the physician and the provider community. So what do they get out of this? And how do you go about the process of recruiting?

RALPH WEBER: Well, the way we go about recruiting is, when we sign up a new group, we look at their most frequently used providers. And we start talking to them. We start reaching out. The typical-- in the typical model, the mainstream model that we've had since for decades now, the hospital is expected to build the chargemaster price. And let me just make up some numbers.

Let's say they bill $100,000 for hip replacement. The insurance company applies a discount, let's say 55%. So there's $45,000 left. The typical worker who earns $37,000 a year might have $5,000 to $7,000 out-of-pocket, OK. So after that, when you take-- when you come down to about $38,000, that's the part that they expect to get from the health plan and then $7,000 from the employee.

Now that $7,000 often is pennies on the dollar are received, if anything. And the $38,000 can sometimes take four to six months to get, going back and forth and back and forth. Hospital CFOs that I've spoken to have told me they're lucky if they get that 2/3 of the time. So it's a long struggle. It's very administratively burdensome to collect that money. What we do is because our average bids come in at 108% of Medicare, so because it's within the plan allowable for most plans, it's based on a prompt pay basis.

So the payment is received very shortly after the procedure. And usually what we do is, the member will either have a small co-pay or sometimes even a reverse co-pay, where they get money for going to a cost-effective doctor. So the doctor receives the money at the time of service, shortly thereafter.

STEVE BLUMENFIELD: So how do you-- how do you do that? How do you ensure that the money changes hands quickly? You have a mechanism within your solution to do that?

RALPH WEBER: Correct. Yes, we do. Yeah.

STEVE BLUMENFIELD: OK.

RALPH WEBER: It's an electronic pay module that does that. Where-- and of course, MediBid is not a fit in an emergency situation obviously.

STEVE BLUMENFIELD: Right.

RALPH WEBER: But most of our procedures are pre-planned to where we have enough time to arrange that in advance.

STEVE BLUMENFIELD: Yeah, that's the type. Sure. So what's your business model?

RALPH WEBER: Our business model is-- and that's changed within the last year. Initially what we wanted to do was take over the whole health plan and substitute a network for a bidding platform. As we got to talk to the larger companies that had very established plans with the big insurance companies, and we were just visiting one last week that had 20,000 employees in the US that wants to incorporate our model as a bolt-on to their existing plan.

So using the bolt-on, there is no disruption to the status quo, none at all. This is just bolted onto the existing plan to where the charges are embedded in the procedures as a percentage of savings.

STEVE BLUMENFIELD: OK. So are you getting paid on a percent of saving basis? You're getting a PEPM from this? What does that look like for your business?

RALPH WEBER: Well, in the past, we got a PEPM. And again, this works well if we do all of the procedures. But if we do a bolt-on, that might be just imaging, it might be just orthopedics, just specialty medications, then we prefer-- actually, I should say the employers prefer to have our fees sort of baked in as a percentage of savings to the procedure or the drug costs.

COURTNEY STUBBLEFIELD: I think that, as you're talking about the model, this is really important, right, for employers listening and certainly many of the clients we work with, the idea that your solution, MediBid, could be offered as an overlay or a bolt-on, as you termed it, to their ongoing health plans, right. Most of our large employers are self-funded, right, work with one of the major or one or more of the major carriers.

And so how-- can you give a little bit more insight into how an overlay approach would work? Would the employer simply fund these separately on a self-funded basis, these claims that come through this way on a separate self-funded basis? Or would you attempt to try to process this through the health plan partner? And is that just dependent on negotiations with whoever the carrier partner might be?

RALPH WEBER: That's exactly correct, Courtney. It depends on the consultant and the carrier partner. They are starting to embrace us more. At first, we were this kind of odd duck. And they just didn't know how to handle it. So we initially paid them outside of the plan on a self-funded basis. Now when you're talking about orthopedics, most of the procedures are well under $50,000. So they would never ever hit the stop loss anyway, so that's hasn't been an issue in the past.

Specialty medications, however, are sometimes in excess of that. So that's one where we've had some interactions with some clients, some sort of medium-sized clients, 4,000 or 5,000 employees or so, where it's a little bit more of a challenge. So it's a matter of working with the carrier partner on those.

COURTNEY STUBBLEFIELD: Gotcha. Yeah, I think a couple other areas I know that employers would be interested in is the geographical influence or aspect of this. So is it possible-- is the attempt made, in most cases, to source a bid in a person's market, right, so travel isn't required? Or are-- is the system and the bidding effort open to travel situations, where someone could potentially travel many states away for a good offer?

RALPH WEBER: Great question, Courtney. And I always say, if Samsung and LG weren't made in Korea, and Sony weren't made in Japan, we'd all be watching RCAs that were 19-inch and cost $2,500. OK.

STEVE BLUMENFIELD: Right.

RALPH WEBER: So global--

STEVE BLUMENFIELD: Wait, is that bad? Because I have an RCA right here.

RALPH WEBER: --competition--

STEVE BLUMENFIELD: What are you saying?

RALPH WEBER: Uh-oh, is it a 19-inch black and white CRT?

STEVE BLUMENFIELD: I don't want to talk about it anymore, keep going.

RALPH WEBER: OK. And the same thing with cars, we'd be driving Edsels instead of Camrys and Lexus--

STEVE BLUMENFIELD: Uh-oh.

RALPH WEBER: --and stuff. So global competition creates a market. Now when I say global competition, I mean not only outside of the US but within the US, traveling from Houston to Phoenix. At first, we limited it to the local geographic area. Then what we found is somebody would make a request. And we got some-- for an example, somebody from California made a request for a hip replacement. He got a bid from San Antonio, Texas.

And he says, my sister lives in San Antonio. Hey, I'll do that. So people started-- because we never know if they have a relative in Orlando or Phoenix or Dallas, so then we just open it up to all bidders all across the geography. But to answer your question, Courtney, we always attempt to meet the geographical constraints that the seeker has requested.

STEVE BLUMENFIELD: Yeah, it really makes it simpler, right? Because just to take the travel element out of it, but that's, as I recall seeing your solution for the first time a couple of years ago at this point, Ralph, I think your initial solution actually even leaned more heavily on helping take advantage of the travel benefits you can get, of better cost.

But what I'm hearing through the rest of this pod so far is you've learned in working with many clients that they really want to have that local option. And maybe that's become more of a shift in the way you deliver care now. Is that an accurate statement? Is that how it worked?

RALPH WEBER: Yeah. Yeah, it is. And the example I gave earlier about the fetal MRI, the seeker was in Houston. And the bidder was in Dallas. Now, if you book three weeks in advance on Southwest, that's $100 return flight. And it's a 38-minute flight. So she had no problem with that. She could have stayed local. And we would have got her better bids than the $2,200 estimate that she had gotten.

But the one that replied that was within the plan allowable, we said, hey, that one's $100 copay. This one is $2,200. You can go to either one. And she made the choice to-- she said, wow, that's great. Yeah, I mean,

for $2,200, I would just not do the procedure. And if you look on Google, Steve and Courtney, if you Google how many Americans cannot afford $400 for an emergency--

STEVE BLUMENFIELD: Oh, it's amazing.

RALPH WEBER: --medical procedure, it will tell you 42, 43% of Americans. So people forego that medical care. When I talk to employers, they say, yeah, but so using your solution, people are going to use medical care more. Well, perhaps, but getting a fetal MRI could reduce, could eliminate a NICU claim in the future.

STEVE BLUMENFIELD: Yeah, I think--

RALPH WEBER: So it's not about--

STEVE BLUMENFIELD: --savvy employers will likely see that people aren't shopping just to see what they can spend money on. They're really doing this--

RALPH WEBER: Exactly.

STEVE BLUMENFIELD: [? --responsibly. ?] What's different about this solution from all the other transparency solutions that we said, and, of course, you're not just a transparency solution. But you do solve an interesting problem that transparency has that difficulty in solving, which is engaging the person and engaging their brain in a different way. Using a transparency tool--

RALPH WEBER: Exactly.

STEVE BLUMENFIELD: --it's nice to see these things, not very actionable. [? You just put ?] what your doctor told you to do. And they said, go down the street because that's who they trust or have a relationship with and all for good reason. But this actually engages you in a different way, by showing the person who's about to click on a button, wow, here's what Medicare's paying. Here's what a reputable known price is. Go ahead and solicit a bid right here.

Take this into an eBay type environment, take this into your own hands. You've engaged the person in a way they've never engaged in health care. I think it's a really fascinating twist on this. And I wonder, how do you get them to do that?

RALPH WEBER: Great question, Steve. First of all, you mentioned the four most expensive words in health care, go down the street, four words, most expensive words in health care, right. And the thing is, we're trained to-- and as Milton Friedman said, now, this is a pop quiz to your Courtney. How many kinds of money are there, according to Milton Friedman?

STEVE BLUMENFIELD: I'm embarrassed to say, as a UChicago grad, I don't the answer to that question.

RALPH WEBER: Two kinds, your money and my money. How many ways are there to spend money? Four ways, me spending my money, you spending your money, me your spending yours, you spending mine. OK. And in those foundations, in those economic foundations is the answer, which-- and our solution.

Because most Americans, once they're past their deductible and out-of-pocket, they just, even if you have transparency, if anything they might pick the higher cost provider, thinking that that's a proxy for quality. But when you have an incentive, such as waived cost sharing or even a reverse copay to where, if they go to the cost effective bidder, they will receive $250 for getting a knee surgery instead of paying, and, of course, travel is paid for, they will become consumers. Because--

STEVE BLUMENFIELD: OK. So plan design changes of incentives, that's the piece you just added there. I want to be really clear about that.

RALPH WEBER: Right.

STEVE BLUMENFIELD: OK.

RALPH WEBER: Yes. And even if it's on a bolt-on--

COURTNEY STUBBLEFIELD: It sounds like plan design in a overlay or bolt-on situation, I think that is a really critical point. How do you create awareness of the program to drive engagement, right? We say all the time, the best solutions and best ideas don't really matter much if we don't get people to actually use them. So I mean, any example of creative ways-- the plan design incentive is a big one-- but even beyond that to create awareness and drive engagement, any examples you could share?

RALPH WEBER: Right. Well, some of our clients, they will use a reference-based pricing type of model to where they cap what the plan will pay. And then if you receive it for under the allowable, there's a financial reward in terms of reduced or waived cost sharing or reverse copay. In other cases, we can still have those rewards built in, to where we really say, hey, look, if you want to go to XYZ hospital, that's fine, subject to your deductible, coinsurance, et cetera.

However, if you want to use the MediBid option, here's going to be your cost. It's going to be a $250 copay, $100 or reverse copay. So we really get them to start thinking about what is the plan paying, and how much is it going to cost you? And that way, you're spending your own money. And you're spending somebody else's money. But you're doing it in a cost-effective manner.

COURTNEY STUBBLEFIELD: I would also think there might be some real just helpful word of mouth that might happen with this kind of program, right. Experience, good experience is going to drive more experience, right. And as people--

RALPH WEBER: Yes, absolutely.

COURTNEY STUBBLEFIELD: --in this population use it and a group talk, I think that could also probably help propel.

RALPH WEBER: And since you're going to start as my Director of Marketing on Monday, I want all these ideas on my desk by Tuesday.

[LAUGHTER]

STEVE BLUMENFIELD: I don't think Director is going to get Courtney.

COURTNEY STUBBLEFIELD: I have quite a few. No, I'm--

[INTERPOSING VOICES]

--ready to help.

STEVE BLUMENFIELD: Push for Chief Marketing Officer at minimum, Courtney.

RALPH WEBER: OK. You got it.

COURTNEY STUBBLEFIELD: Just add it to my other three or four things, no problem.

RALPH WEBER: Sure.

COURTNEY STUBBLEFIELD: You know, one thing I do-- you've mentioned here the kind of services. I think we've hit on probably some of the common services that you see. But what are the top two or three, maybe

even five, things that come through the site from a bid perspective? What are people looking for on your site the most?

RALPH WEBER: Orthopedics are very high. Orthopedics are very high. Colonoscopies, believe it or not, are very high. Imaging, MRI, CTs, et cetera are pretty high, general surgeries, hernia repair, hemorrhoidectomy, hysterectomy, those types of things. I think that pretty much rounds up our top five in terms of medicategories anyway.

COURTNEY STUBBLEFIELD: OK.

RALPH WEBER: Now, Steve, you're kind of pausing on the colonoscopy thing. Because you're probably thinking, well, that's preventive care. So why would that be high? Here's what we found. Sometimes when a colonoscopy turns from a screening colonoscopy to a diagnostic colonoscopy, sometimes we'll see a second facility charge being applied. And then all of a sudden, it goes from zero cost sharing to potentially deductible.

So, you know, we have actually found that that has become a growing need. And it, you know, certainly isn't the very top of our charts. The other thing about colonoscopies that's very interesting is from state to state the different medical boards have different requirements. In some states, you have to be under general anesthesia. In some states, sedative in a doctor's office.

COURTNEY STUBBLEFIELD: Yeah, Ralph, I think the preventive, the dynamic you just described, the fast conversion of something from preventive to diagnostic actually exists in a lot of-- several areas, I mean, mammograms are another area where--

RALPH WEBER: Right.

COURTNEY STUBBLEFIELD: --it can very quickly turn to the need for a MRI with contrast. And the price just infinitely increased. The other thing I was curious about that I think employers would ask, and I don't know if this is a space you cover or would, but this is obviously an interception of a patient's need where we could actually talk about the need and treatment decision support.

So is the bid platform really operating from the point in time when someone says, I need this, and I know I need it. And I don't need further validation that I need it. Or would you ever envision when they meet with the doctor, does some of this care get diverted, like it wasn't actually needed? Does that ever come into play?

RALPH WEBER: Absolutely, Courtney. And again, to use Steve's words, go down the street, if you're told go down the street, you go down the street and you get the surgery. When you're putting the request on MediBid, you have potentially thousands or tens of thousands of doctors that are looking at it. And you'll get an inherent built-in second opinion. Mayo Clinic, I'm sure you're familiar with the study that said 88% of the time when somebody gets a second opinion, the original diagnosis is overturned or modified.

So you'll get people requesting a knee replacement. And then you'll get somebody, orthopedic surgeon say, you know, I've looked at the X-rays that you've uploaded. There's no bone on bone. The plicas are in good shape. I think a knee scope is all you need. And somebody else will say, hey, have you considered regenerative medicine? It's minimally invasive. It costs less than $2,000 compared to $17, $18,000 for a knee replacement.

STEVE BLUMENFIELD: So what do you do at that point? I mean, I think that's fascinating. It also creates complexity for a consumer who may be already at the edge of their abilities and shopping in the first place. How do you help them decide which of those to choose?

RALPH WEBER: What we do is at that point in time it goes to the care coordinator for the plan that does the prior authorization. And we say, OK, look, let's-- here's a possibility. And of course, usually it is in orthopedics where there's time, you know. And then we involve them. And we say, hey, look, what do you think? Yeah, we could turn-- we could do the regenerative medicine. And you know, yeah, that'll work.

STEVE BLUMENFIELD: Is this experience in app, is it a phone call, is it a computer screen? What does this feel and look like for the member?

RALPH WEBER: Any of the above. We have a phone app, computer app, or a phone call. And we will take any of the above. We'll work with the people. Usually when they-- with an employer-sponsored health plan, they have their own log-in which is based on their subscriber ID and a password that we give them in advance.

They can log on. If they're not comfortable with that, they'll just call us. And they'll say, I work for Acme Widgets, and I need a knee replacement. What do I do next? OK, are you in front of your computer? And then we will walk them through it.

STEVE BLUMENFIELD: All right. So Ralph, think about a metaphor for the problem that MediBid is trying to solve.

RALPH WEBER: OK. So I think, we have been called the Priceline of health care. When Priceline was first started, they said, wait a second, I don't get it. Why would somebody not plan in advance? But when you think about it, once the door closes on that airplane, every empty seat is like spoiled produce. It's waste. If you could sell that seat for even $79, the incremental cost is a can of Diet Coke and a bag with 17 peanuts in it.

[LAUGHTER]

So it's incremental revenue. And it's the same with hospital beds. Sometimes there's a hospital that has an 80% occupancy rate during certain periods of the time. And one interesting thing, Steve, that we've seen is, as you know, the last three, four months of the year are the busiest for doctors and hospitals, because everybody's used up their deductible. And they get everything done.

STEVE BLUMENFIELD: Sure.

RALPH WEBER: The first few months are the slowest. So our average bids are actually lower in February and March than they are in October and November.

STEVE BLUMENFIELD: Well, as a huge William Shatner fan and a big Star Trekkie, I can definitely applaud the metaphor for Priceline. Thanks for that one.

RALPH WEBER: Courtney, here's one thing that I need from you as chief marketing officer. I need you to get a contract with William Shatner for us.

[LAUGHTER]

STEVE BLUMENFIELD: That's great.

COURTNEY STUBBLEFIELD: Now I think the seasonality that you described and tapping into the cycles, right, when both in terms of the excess capacity, potentially, for some type of care, as well as that value prop of getting paid quickly, so kind of leveling out their revenue is fascinating.

RALPH WEBER: Tomatoes are more expensive in January. OK. So the economy works everywhere. And guess what, it works in medical care, too. The prices are lower when there is an excess of supply, empty hospital beds, you know. So we're finding that these elements of the economy are actually working where nobody thought they ever would.

STEVE BLUMENFIELD: All right. So I'm getting a clearer image here now. We have Shatner at a store looking at tomatoes saying, this is too expensive, time to get my hip replaced.

[LAUGHTER]

RALPH WEBER: I like it. I love it. OK. That's great.

COURTNEY STUBBLEFIELD: I was curious, though, reaction from the health care sector, I mean not the supply side, the providers, but in terms of insurers and carriers and other players that have solutions that typically may work more in a more traditional manner with, you know, through the third-party payment system kind of thing and insurance, what kind of feedback have you had? Reaction, they see this as a real threat?

RALPH WEBER: Well, you know, some people whose income is based on the higher the spend, the higher the income would probably be threatened by it. And we've seen that. We've been blocked in the past by people that have this model. The consultant that embraces new technology, new savings, increase in quality, decrease in cost, that can really explain it, and it's really so simple to explain to employers.

And as we see the baby boomers sort of moving out of the C-suite and younger generations, Gen X, Y, and millennials starting to move in as decision makers, we're saying, OK, yeah, we don't need to embrace the status quo. Why can't economic functions work here? And so we're seeing a sort of a change of the guard in that regard.

COURTNEY STUBBLEFIELD: That's great. So Ralph, if in five years you have a cover story in your favorite business magazine, what would the headline be?

RALPH WEBER: I think it would say MediBid solves health care by, you know, what you said in your introduction Steve, by combining transparency with competition through a bidding platform. And that's maybe kind of long. But putting health care in the hands of people that can afford maybe $250 but not $1,000.

STEVE BLUMENFIELD: So you're going big, solves health care.

RALPH WEBER: Or even uncomplicates health care. Because it doesn't have to be this complicated. It really doesn't.

STEVE BLUMENFIELD: It doesn't. But you're going to have to decide. And maybe Courtney as your marketing go-to person can decide which of those to use.

RALPH WEBER: OK.

COURTNEY STUBBLEFIELD: Yeah. Or widespread acceptance, I mean that would be another really nice goal, right. That what, you know--

RALPH WEBER: Absolutely.

COURTNEY STUBBLEFIELD: I mean, is this a win-- a true, one of the first and only maybe, win-win situations.

RALPH WEBER: Absolutely. Think about it 30 years ago, if you said, just Google it, they'd say, what? OK.

STEVE BLUMENFIELD: Right.

RALPH WEBER: So I have a vision where somebody is just going to say, just MediBid it.

STEVE BLUMENFIELD: MediBid it.

RALPH WEBER: You know.

STEVE BLUMENFIELD: MediBid it.

COURTNEY STUBBLEFIELD: I like it.

STEVE BLUMENFIELD: We may have a winner. That's it, Medibid it.

COURTNEY STUBBLEFIELD: Yeah.

RALPH WEBER: There we go.

STEVE BLUMENFIELD: All right.

RALPH WEBER: OK.

STEVE BLUMENFIELD: Ralph, if MediBid were a mythological creature, like a Greek god or goddess, what would it be and why?

RALPH WEBER: A unicorn.

STEVE BLUMENFIELD: A unicorn.

RALPH WEBER: Definitely a unicorn.

STEVE BLUMENFIELD: OK.

RALPH WEBER: Because they said it would never work in health care, because health care was different.

STEVE BLUMENFIELD: All right, interesting.

RALPH WEBER: And they say unicorns don't exist, but I've seen them. I've been to [? Florida. ?]

STEVE BLUMENFIELD: You have seen them.

RALPH WEBER: Yeah.

STEVE BLUMENFIELD: You have. Were they-- were they really soft and, you know, you like could put your head on it and rest. That kind of unicorn that you saw?

RALPH WEBER: Yeah. Absolutely. Yeah.

STEVE BLUMENFIELD: After--

RALPH WEBER: Well, and like in a zoo, too, yeah. I mean, like I kind of suspected that it was like maybe kind of altered, like maybe it was a plunger strapped onto a little pony's head or something.

STEVE BLUMENFIELD: A plunger.

RALPH WEBER: But I don't know. I believed it.

STEVE BLUMENFIELD: This unicorn has stripes.

COURTNEY STUBBLEFIELD: I think we have some new logos forming here. This is great.

RALPH WEBER: Yeah.

STEVE BLUMENFIELD: Well, Ralph, Courtney, this has been a pleasure. I've learned a ton. Thank you so much for being here with us.

RALPH WEBER: Thank you, Steve.

COURTNEY STUBBLEFIELD: Fascinating discussion. I have to ask one question for the women who are listening here. So can I ask for bids on plastic surgery?

RALPH WEBER: Absolutely. Yes, that's also, you know, I forgot to mention that. That's also a very-- not only plastic surgery but cosmetic dental, a very, very large market. Because-- and that, of course, we've seen economic principles more at work for longer times. And even like with LASIK, because that's where you're spending your own money.

STEVE BLUMENFIELD: Interesting. And Courtney, you mentioned that for women. But I can definitely see circumstances where that's not just for women as well.

COURTNEY STUBBLEFIELD: Absolutely. Yeah, you're totally right. No, that's great to know.

RALPH WEBER: And of course, Courtney is going to get an employee discount, because she starts on Monday so.

COURTNEY STUBBLEFIELD: That's great.

STEVE BLUMENFIELD: All right. Thanks so much. I've learned so much today. It was terrific having everyone here for our podcast. Thank you first, our guest, Ralph Weber.

RALPH WEBER: Well, thank you Steve for having me. Again, I enjoyed it as I always do when you and I meet and speak about these types of things.

STEVE BLUMENFIELD: Excellent. You've built a wonderful solution here with MediBid. And thanks Courtney Stubblefield, our expert, for your points of view.

COURTNEY STUBBLEFIELD: Thanks Steve and Ralph. I really enjoyed the conversation today.

STEVE BLUMENFIELD: And thanks mostly to you, our listeners, for being here. If you'd like to learn a little bit more about MediBid, you can check them out and actually get a sense of what the savings opportunity is by looking up MediBid.com, M-E-D-I-B-I-D dot com and clicking the button. Ralph.

RALPH WEBER: There's an orange button that says Cost Calculator. And that'll show you some of our average costs.

STEVE BLUMENFIELD: Excellent. Thanks everyone for being here. And thanks for listening to "Cure for the Common Company," also going by "Cure for the Common Co." Have a great day.

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