The Health Care Blog
Everything you always wanted to know about the Health Care system. But were afraid to ask.

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Crowdsourcing, Price Formation, and Health IT

By JOHN R. GRAHAM

From the perspective of the average patient, going about his life unconcerned about health policy or economics, what is the most frustrating characteristic of U.S. health insurance? Surely, it is the madness of the billing cycle: Never knowing how much a medical service costs until long after you've received it, and sometimes only after a flurry of phone calls and paperwork that can take months to clear up.

This is surely why Michaela Dinan's "winning entry" in a national essay contest, which invited people to submit anecdotes "illustrating the importance of cost awareness in medicine," has struck such a chord. Ms. Dinan's story concerned a billing error for inserting an IUD. Before the procedure, the patient learned (via "a few keystrokes") that the cash price would have been $843.60. Insured, her out of pocket cost was to have been about $200. Instead, she received a bill for $1,100 that took months to sort out. I suspect that most readers and contributors at The Health Care Blog will use this story as further evidence of the need for a massive national investment in Health IT, along with Patient-Centered Medical Homes, Accountable Care Organizations, adherence to "meaningful use" standards, *et cetera.*

But this fails to identify the real culprit: Over insurance. Adjusting claims always includes friction, largely because of moral hazard. That's why insurance should be used rarely and only for catastrophic, unanticipated events — not birth control, which is planned, preventive care. For health care, the problem is even worse because very few prices are formed via normal market processes. Automobile insurers have it easy: The price of a car, and therefore every part of a car, is formed via normal market processes. Auto insurers are price-takers, not price-makers. My auto insurer's liability to me is limited to buying a new Toyota 4-Runner, for which the price is readily available. (I'm oversimplifying here, referring only to collision coverage, not bodily injury.)

One of the most frustrating and misleading claims of health insurers is that they add value by negotiating network contracts with providers. In fact, these network contracts destroy value because they prevent patients and providers from using prices to signal value to each other. As a parallel, imagine that instead of buying our cars first and *then* insuring them, we did the reverse That is, imagine that we bought auto "insurance" and *then* went shopping for a "free" car from a network of dealers contracted with our auto "insurer." The ability of drivers and carmakers to communicate value to each other would be hopelessly malformed by the bureaucratic friction imposed by such a "system."

This is what health insurers do, and they support their claims to add value by (unwittingly) falling back on a version of John Kenneth Galbraith's notion of countervailing power: The individual cannot effectively negotiate with powerful providers, so the health plan acts as a bulk-buyer, ratcheting down fees charged by powerful hospitals and organized medicine.

While never a robust claim, it is even less credible in an age where individuals can use technology on their own to get better prices from suppliers. For example, Groupon is an Internet-based business, launched in 2008, through which businesses offer discounts if enough people sign up for a deal within a period of time. For example, a restaurant might offer 50 percent off if 100 people sign up for it within 24 hours. Needless to say, potential customers madly e-mail, Tweet, and IM their friends in order to "tip" the deal. Last December, the business press reported that Google had offered $6 billion to buy Groupon. Investors rejected the offer, and Groupon is now preparing for an IPO in 2013.

With a little more sophistication, there's no reason why such an approach couldn't work for health care — especially in the area of preventive care. Suppose an annual physical for a middle-aged man costs $500. Imagine that Groupon collaborated with primary-care practices nationwide to buy an ad at the Super Bowl offering physicals for $200 if a certain number of middle-aged men in each neighborhood signed up within a couple of days after the big game. Surely, some fraction of Doritos-munching, beer-drinking, football fans would encourage each other to get their cholesterol, blood pressure, and BMI checked.

I expect that such a combination of peer pressure and price incentives would also improve adherence to therapy in communities of patients with chronic conditions. Unfortunately, we are unlikely to find out, because the government is more interested in using IT to empower various committees, commissions, and task forces, than to empower patients and entrepreneurs.

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