Criminals, Victims & Innocent Bystanders: The Prisoner's Dilemma of Health Insurance

The primary reason you are all assembled at this conference today is that you desperately yearn to return to the era of a free market for health care that existed prior to the founding of AAPS back in 1943. And you are willing to do just about anything to make this happen.

Yet, without realizing it, since the meeting began this morning, all of you in this room have just witnessed and participated in an event that illustrates how this dream can become a reality. This event is so special that economists call it a miracle. Yet it's so trivial, that none of you even bothered to notice it.

I don't expect anyone to be perceptive enough to identify the details of what just happened. But I will give you a hint: I have performed this experiment — and no doubt you have all participated in it — many times in the past. However, this incredible successful triumph represents only half of the story I want to tell you today.

Before I reveal the details of our collective unique accomplishment of the past hour, let me provide you with some background. For the past six decades the level of freedom in health care in the United States has been declining dramatically. For this generation of health care, those with medical training who come in contact with patients — i.e. doctors and nurses — are financially and professionally worse off. While most of those in the health care industry who do not interact with patients — i.e. actuaries, accountants and attorneys — are financially and professionally better off.

This simple observation sums up the three fundamental problems of health care in the United States.

The first problem is that the wrong people are making the decisions. What should be a two-party transaction, between patient and physician, unfortunately is a four party transaction, complicated by health plans, employers and the government. Health care should be purchased by patients, and managed by physicians. Instead it's purchased by third party payers and managed by health plans. The people with the most knowledge and in the best position to affect the outcome are taking orders from faceless entities — who will never meet the patient or physician — and who aren't responsible for the result.

The most disastrous manifestation of this occurred back in the 1990s, with the creation of Physician Hospital Organizations, or PHOs, which were extensions of HMOs, and which were founded on the idea that actuaries — who have no medical training — would tell doctors how to practice medicine. While physicians — with no actuarial training — would manage health insurance risk. PHOs no longer exist today and HMOs are dying out. Like so many dot-com start-ups, they had a short-lived meteoric rise and crash leaving a scorched-earth trail of bankruptcies among the physicians and hospitals who invested in them.

A few years ago I attended a conference where the featured speaker was an actuary who made his fortune designing PHOs, who appeared to under the age of fifty, and comfortably retired. Reflecting on the failure of the capitated PHO model, he placed the blame solely on the doctors. Because, as he said in exasperation, "Doctors don't understand insurance." At the reception

following the conference, I tried to explain to him that actuaries don't understand medicine. And that perhaps a better division of labor would be for actuaries to manage insurance risk, and to let doctors practice medicine.

He resolutely held to his position. In retrospect, it's easy to understand why. The capitated PHO models he designed made him rich beyond his wildest dreams. It would be much easier to have a dialogue with him, had he lost his life savings, and been driven into bankruptcy. Impoverished doctors I've discussed this topic with have no trouble identifying the fundamental flaw with the PHO model. Because they have paid an enormous price to learn this painful lesson.

The second problem is that the health care system is purposely designed to do the wrong things. It makes it harder, not easier, to obtain health care. And it adds waste and cost into the process — what the world-renown Toyota production engineer, Taiichi Ohno, referred to as *muda* — which is any activity that adds cost, but does not add value.

There are seven categories of health care *muda* or waste:

- **Delay**: Idle time spent waiting for something, such as pre-certification approval, utilization review (UR) or payment from an insurer.
- **Movement**: Unnecessary movement of products, people, or information, such as requiring patients to see a primary care physician, before being referred to the specialist they knew they wanted to see in the first place.

- **Oversight**: Having one worker, such as a case manager, watch another worker do his job. If a worker can't be trusted to do a job, an efficient enterprise either retrains or replaces the worker or redesigns the task.
- **Inspection**: Having one worker inspect the work of another after it has been completed, as in retrospective reviews. The goal of worker autonomy is self-control and self-inspection. If someone is unable to determine whether his work is acceptable, then he is not competent to do the job and should be replaced.
- **Rework**: Performing the same task a second time, such as giving a needless second surgical opinion or re-filing a claim.
- **Overproduction**: Manufacturing of products that aren't needed, such as defensive medical tests or processing of unnecessary claims information.
- **Defective Design**: Design of goods that do not meet customer needs, such as CPT, DRG and ICD-9 coding schemes, which were designed for the convenience of third party payers, not for the treatment of sick patients.

If someone in the audience were to suddenly grab his chest and double-over unconscious, the first question someone asks is, "Is there a doctor in the house?" No one ever desperately asks, "What's the diagnosis code for acute heart failure?"

This brings to mind the amusing story about the group of college fraternity brethren, who had a ritual every Saturday evening of getting drunk and telling the same jokes to each other. After a while, when everyone knew all the jokes, they decided to save time by assigning numbers to

each of their favorite jokes. So members of the fraternity would simply shout out a number and everyone would bust out laughing.

Once, when a new member was initiated into the group, he was informed of the numbering system. But, rather than taking the time to learn which joke was associated with which number, he thought he could take a shortcut and become the life of the party by simply shouting out the number 17. When the group responded with an agonizingly long and cold silence, a friend whispered, "Well, I guess you had to be there."

In a similar vein, I imagine a group of doctors sitting at a bar shouting out CPT codes or ICD-9 codes and laughing hysterically as though they were punch-lines to outrageously funny jokes.

There is a priceless story about Taiichi Ohno that is recounted in the forward to the 1988 edition of Henry Ford's classic book on manufacturing titled, *Today and Tomorrow*, originally published six decades earlier in 1926. In 1980 — when the quality of American cars was at its worst, and when America's Big Three automakers humbly made the pilgrimage to Japan, cap-in-hand to learn the "secret" of their methods — a group of engineers from Ford Motor Company bombarded Taiichi Ohno with questions about what inspired his thinking on manufacturing and quality. Ohno just laughed and told them that he learned it all from Henry Ford's book, *Today and Tomorrow*.

The lesson to take away from this story is that, like the auto industry, the medical profession is a classic case study of the Chinese business proverb, "shirtsleeves to shirtsleeves in three

generations." Just as it took three generations to bring the once mighty U. S. auto industry to its knees, in the span of three generations we have brought the U. S. health care system to its knees as well.

The third problem with the U. S. health care system is that — believe it or not — all four participants: patients, physicians, third party payers, and health plans are logically and rationally acting in their own best interest.

How can this be? If everyone hates managed care, how can everyone be acting in their own best interest?

The answer is that our health care system represents the natural evolution of the *muda* of a defective design of employer-sponsored health care, driven by the Internal Revenue Code (IRC). Why have patients, physicians, payers, and insurers logically and rationally added all this *muda* — this waste and cost — into the health care delivery process? It's because information, responsibility, accountability and trust, are improperly assigned or missing entirely.

Because employers and the government have been paying for the vast majority of health care, patients logically and rationally have not been responsible for their health and have not been held accountable for the health care they use. Because they have little or no information about cost or treatment options, their view of health care is roughly equivalent to a six-year old sitting on the lap of Santa Claus: offering nothing, while asking for everything.

Economists call this "acting from a state of rational ignorance." Rational ignorance is defined by the phrase, "I don't know; and I don't care." And you cannot achieve an efficient allocation of resources with rationally ignorant participants. If you could, there would be lots of six year-old corporate CEOs.

Because physicians have little information about what the buyers of their services are willing to pay, they logically and rationally have charged prices and delivered services designed to grow their practices and to advance the medical profession. Like military defense contractors during the Cold War, cost was not a primary consideration. They were trying to design and build weapons to fight and defeat an enemy — in their case disease — more than stay on a budget. Cost overruns were not only acceptable, they were almost considered desirable.

Because employers and the government were paying the bill for all this health care, they were logically and rationally forced to take dramatic measures to control costs. All employers could hope to accomplish was to deter and prevent patients from seeking medical care and to deter and prevent physicians from providing it. In fact, the U. S. steel industry's failure to comprehend and account for the seriousness of this flawed health care design, has been one of the major factors in its demise.

Because health plans were the intermediaries of nearly every health care transaction, and because neither patients or physicians were responsible and accountable for costs, their logical and rational response in the messed-up world of employer-sponsored, government controlled, third-party, pre-paid health care, was to micromanage patients and physicians by adding *muda* —

Delay, Movement, Inspection, Oversight, Rework, Overproduction and Poor Design — into every step of the health care delivery process.

So the result is that we have four participants — patients, physicians, payers and health plans — all of whom hate their situation, but all of whom are logically and rationally acting out of their best interests. It's a classic example of the natural product of defective design: *Gresham's Law* of media, where the bad practices, as prescribed by law, dominate the market and drive out the good practices.

Do patients enjoy having no choice of health plans or doctors? Do physicians enjoy asking permission from a Utilization Review manager to treat a patient? Do insurers enjoy foregoing profits to hire case managers to monitor physicians? Do employers and the government enjoy paying for all this *muda*, all this waste? Obviously, the answer is "No." But not so obviously, they all do it, not because they enjoy it; they do it out of self-defense.

If patients don't follow all the rules of their prepaid health plans, they have to pay for their health care a second time, on their own, with their after-tax earnings, at double the price. If physicians don't join HMO and PPO networks, and follow the protocols, their patient base evaporates. If health plans don't micromanage patients and physicians, costs rise dramatically. And if employers don't offer health benefits, they risk losing their workforce.

This endless cycle of futility brings to mind the famous poem about the absurd reality of the ideal socialist utopian dream:

- There is no unemployment; but no one works.
- No one works; but everyone gets paid.
- Everyone gets paid; but there is nothing to buy.
- There is nothing to buy; but everyone owns everything.
- Everyone owns everything; but no one is satisfied.
- No one is satisfied; but 99% of the people voted for the system.

Well if you hated your personal situation you would try to change it. And if many people hated their collective situation they would logically and rationally vote to change it. So what's the problem?

We all know how difficult it can be to quit smoking or lose weight. It's tough enough making the personal decision to throw away the cigarettes or stick to a diet. Yet, while we all know many people who have done so, it's an obvious fact of life that the vast majority of smokers refuse to quit and the vast majority of obese refuse to lose weight.

What if we changed the rules of life such that for someone to quit smoking he had to get a majority of smokers to agree to quit with him and to stay true to their promise? And if most smokers refused to quit — or reverted back to their bad habit of smoking — he would be forced to smoke for the rest of his life.

Or what if the laws of society were changed such that a local restaurant, grocery store, or ice cream parlor, could sue an obese person who goes on a diet for lost revenue. What if an obese

person's legal liability for food consumption was interpreted by the courts to be as large as a doctor's liability for surgical malpractice? How many people would have the courage to go on a diet, if all it took were one groundless lawsuit by a disgruntled grocer to wipe out his life savings, and force him into bankruptcy?

This brings me back to the unique event I alluded to at the beginning of my speech in which you all witnessed and participated. I logically and rationally did a simple and trivial thing at this conference that I would never do in the U. S. health care system, because the consequences would be severe and potentially disastrous.

The trivial and simple thing I did was to leave my computer on this table in a room full of people I have never met while I left the room and went to the bathroom. Now I don't normally do this. I would never do this in an airport, coffee shop or bookstore. I logically and rationally did it here this morning because I had an enormous amount of advance information: that you are all members of the same organization — AAPS — and I had an enormous amount of trust in what this organization represents.

I also knew that there exists an unwritten, unspoken, bond among you which holds you accountable to each other. Anyone of you could have stolen this computer while I was gone. However, there would have been a hundred witnesses to the theft who would have identified you as the culprit.

Now don't take this complement about your integrity too seriously — for two reasons. First, I have even left my computer out in the open when I've spoken to a group of actuaries — and remember that actuaries are the profession responsible for the financial integrity of Social Security and Medicare. Second, while I, as a generic actuary, trust you collectively here today as a physician to hear me speak, I, as a generic actuary don't trust you individually tomorrow when you return to your offices and practice on rationally ignorant patients that I am financially responsible for.

The reason why I trust you collectively here today, but don't trust you individually tomorrow, is explained by two economic principles of game theory:

- The first principle is known as the *Prisoner's Dilemma*, which grew out of the nuclear arms race of the Cold War.
- The second, and closely related principle, is known as the *Nash Equilibrium*, which was introduced into the popular culture a few years ago by the book and movie, *A Beautiful Mind*.

The *Prisoner's Dilemma* defines the rules of the game or the environment in which you operate, while the *Nash Equilibrium* tells you how to play the game. The three basic categories of *Prisoner's Dilemma* economics are: *win-win*, *win-lose*, and *lose-lose* scenarios:

- *Win-win* scenarios are the domain of free-market economic exchanges, where you get what you want, in exchange for giving me what I want.
- *Win-lose* scenarios are the domain of sports and games, where there has to be one winner and one loser.

- *Lose-Lose* scenarios are defined by the domain of undesirable choices that we sometimes face: For example, should the United States risk bankrupting its economy to build a military-industrial complex to neutralize the threat from the Soviet Union? Or should the United States unilaterally disarm and risk handing Western Europe to the Soviets?

It goes without saying that you entered the medical profession with the idea that your career would be a *win-win* scenario. And that many of you now find yourselves in *win-lose*, or *lose-lose* scenarios. The authority that controls the game sets the rules that determine the scenario. The *Prisoners' Dilemma* problem we must face is the fact that none of the four participants in the U. S. health care system — patients, physicians, payers and health plans — are able to control the game or set the rules, which are defined by the Internal Revenue Code and state insurance departments. They are all stuck in the same canoe headed straight for a waterfall without a paddle to steer, change course, or slow down.

The *Nash Equilibrium* holds that in a scenario involving many people, you and I will change our behavior to maximize our wealth when we have knowledge of the strategies of the other participants. This is why employers offer health benefits for their workforce instead of paying higher wages. It's why patients purchase health care through their employer instead of on their own. It's why physicians join health plans and accept Medicare assignment. And it's why health plans micromanage patients and physicians.

All these participants didn't spontaneously decide on a whim, or a roll of the dice, to engage in all this *muda* of managed care. They did so because that's the way our health care system has

evolved based on everyone logically and rationally acting in their own best interest over time, given the rules of the tax law and the knowledge of how the others will respond. The Nash Equilibrium problem we must face is that the U. S. health care system has evolved as an irreversible one-way process similar to baking a cake. You can bake a cake starting with an egg and two cups of flour. But you can't start with a cake and recreate the separate egg and dry flour.

The *Nash Equilibrium* also represents the two extremes that further explain the *lose-lose* game of managed care *muda* that we're all forced to play:

At one extreme of the *Nash Equilibrium* is the "tyranny of the majority." It is sometimes called the *herd mentality*, where everyone is coerced into following the crowd, or going along to get along. Because standing-out alone — opposed to everyone else — is too costly. Common business examples of this are restaurants and car dealers, which are usually grouped together geographically to allow for easy comparison shopping. If you want to open a new restaurant or car dealership, you're better-off doing so in the same locale as your competitors. Otherwise no one will bother to travel to the other end of town just to sample your wares.

The herd mentality is why physicians join health plans, why health plans micro-manage physicians, why employers offer health benefits, and why employees submit to the restrictive rules of their employers' health plans. They do so, not because they want to, but because everyone else does. If they try to buck the prevailing trend, they are left out in the cold to starve.

At the other extreme of the *Nash Equilibrium* is the tyranny of the minority. It is sometimes referred to as the *lone wolf* or *mad bomber* scenario, where there is the one-in-a-million chance that there exists a madman with an explosive device who can destroy everything. The obvious example here is airport security. Only one-in-a-million passengers wants to hijack or blow-up a plane. But because this risk exists we are all forced to endure intrusive searches at airports. In fact, we actually prefer to have these searches. And most of us would refuse to fly without them, because they assure us that the other passengers — or participants — are legitimate customers who don't represent a threat to us.

You may recall that a similar scenario occurred back in 1980, when seven people were murdered by Tylenol laced with cyanide. The pharmaceutical industry reacted by demanding that Congress pass legislation requiring all over-the-counter medications to package their products in tamper-proof containers.

The *lone wolf* threat is why health plans require patients to be routed though physician gatekeepers and why they try to micromanage the treatment of every patient. For all but the largest employers, all it takes is a few unsupervised patients seeking unlimited care, or a few unsupervised physicians providing unlimited care to bust the annual budget for the company's health benefits.

So how do we dislodge ourselves from this mess of the *Prisoners Dilemma* and *Nash Equilibrium* that patients, physicians, payers and health plans have all backed themselves into? Let's look at two examples in other sectors of the economy where *muda* has been eliminated.

Airlines and public utilities provide a solution to the *herd mentality* dilemma of excess *muda* or waste. For more than a decade, there has been no reason for your telephone, electric or gas utility to send you a bill. And there has been no reason for you to waste your time writing a check and mailing it in. This can all be handled electronically and automatically — without any paper or human intervention. Most utilities now process payments this way. But there is still some resistance and fear among customers: resistance to changing old habits and fear of the unknown of electronic payment.

Utilities are fighting this resistance by offering the convenience of automated paperless payment along with the assurance that payment will be made on the due date — so customers will not lose any interest on their funds. The next logical step is to either add a surcharge to customers who pay by manual check or to offer a discount to customers who pay electrically. Airlines are doing both: adding surcharges to tickets sold through travel agents, while simultaneously offering discounts for tickets purchased over the Internet. Once the herd grows large enough and achieves a critical mass, the lagging minority is faced with the choice of adopting the new standard or paying ever-larger surcharges.

Private schools and bottled water point the way to a *lone wolf* solution. Why would anyone pay a second time to educate their children when they have already paid for public schools? And why would anyone pay for bottled water when they can drink from a public fountain for free? The reason is that while *Gresham's Law* holds that the bad drives out the good, it doesn't eliminate the good. It only makes the good a little more expensive and a little harder to find.

In fact, a necessary requirement for *Gresham's Law* is an absence of discriminating prices or a law requiring that two different goods have the same price, such as a one dollar silver coin and a paper one dollar bill. If the government decrees both of these to be of equal value, people will horde the silver coins and circulate the worthless paper currency. Similarly, there would be no market for bottled water if there was a law requiring it to be priced the same as water from a public fountain. When the superior good can command a higher price the destructive phenomenon of *Gresham's Law* is averted.

Twenty years ago Perrier was the only brand of bottled water available. Today bottled water represents a huge segment of the soft drink market occupying an entire section of grocers' shelf space. Twenty years ago home schooling was so rare that it was illegal in some states. Today it is an established nationwide movement more than a million strong.

This is why I'm closely following the fortunes of the Dr. Robert Berry's PATMOS model, and Dr. Todd Coulter's Doctor on Duty models. Because they are combination of the *herd mentality* and *lone wolf* tactics. Like the utilities, they get both sides to agree upfront to eliminate the obvious and expensive waste in the process — to everyone's benefit. And like private schools, they offer a vital product so superior to the generic public standard dictated by *Gresham's Law*, that customers are willing to pay for it a second time just to make sure they get what they want.

The most significant positive trend today is that employers are now moving away from a first-dollar HMO benefit structure — where they tried to micromanage and pay for every health care

service — to higher deductibles and personal health care spending accounts (HSAs). In the bull market of the 1990s, when employees were defecting by the busload to join dot-com startups, the standard response of employers was to expand their health benefits in any way possible.

In today's bear market climate however, employers are looking to cut health care costs any way they can. And they have little fear of resistance from their employees. As patients move into higher deductible plans with more discretionary personal health care spending accounts, three things will happen: one is that there will be increased pressure on Congress to expand discretionary personal health care spending accounts such as HSAs and FSAs. Second, as patients take greater control over the health care they purchase, the more cost effective this health care will become. And third, the less health plans and employers will feel the need to micromanage it.

Of course, except for home schooling, the examples I gave of the airline, public utility and bottled water markets are dominated by large established conglomerates with huge advertising budgets, fully staffed with Washington lobbyists. You're just one physician trying to manage a solo practice. How can these scenarios apply to you?

This brings me to the other half of the story I've come to tell you today, which is the saga of the three pivotal kingpins of the PC technology revolution: Bill Gates of Microsoft, Steve Jobs of Apple, and Gary Kildall of Digital Research. Everyone has heard of Gates and Jobs, but only a few select computer geeks remember Gary Kildall.

But in the early 1980s, these three were equals and they all shared an intense fanatical hatred for their common enemy: IBM, or Big Blue. Gates owned the Quick BASIC programming language, Jobs controlled Apple Computer, and Kildall owned the DR-DOS operating system. Today Gates has 97% of the PC software market and is worth hundreds of billions. Jobs has 3% of the PC market and is worth hundreds of millions. While Kildall died in a bar fight in 1994, and his DR-DOS operating system is extinct.

How did these three men, locked neck-and-neck halfway into a three-way horserace for the future of the 21st century, finish with 97%, 3% and 0% of the ultimate prize? The answer for Bill Gates is his good bedside manner. The answer for Steve Jobs is greed. And the answer for Gary Kildall is arrogance.

Allow me to explain, starting with Steve Jobs, who could have had Bill Gates 97% market share, or at least a 30% - 50% market share, except his greed got in the way. Jobs simply couldn't contain his childish impulses and demanded that he have it all. He chose to adopt the HMO model for Apple Computer. Just as the HMO is supposed to be all health care, to all patients, at all times, in all places … on the HMO's terms (of course), Jobs wanted to control the customer by owning every piece of the personal computer: the hardware, the monitor, the disk drive, the operating system, the software, and the printer. Everyone who purchased a PC from Apple would have to buy everything from Apple. They wouldn't be able to go outside the Apple network of products. They would become captive slaves to Apple Computer's *1984* vision of the PC market.

Well, if "greed is good," and "selfishness is a virtue," Apple computer is a classic case study of too much of a good thing. Because PC consumers are no different than health care consumers. They bitterly resent being treated like cattle, to be milked dry of their assets, and ultimately led to a slaughterhouse. They may tolerate some indignities for a short period, but they will soon wise up, discover their freedom, and defect by storming the Berlin Wall that imprisons them.

The story of Gary Kildall and Bill Gates can be summed up by Woody Allen's classic observation, that 85% of life is just showing up. The reason Gates is the world's richest man and Kildall only lives on as an answer to a trivia question is that IBM — in need of an operating system for its new PC — called on Bill Gates. Gates told IBM that Microsoft didn't have an operating system, and that they should talk to Gary Kildall, who did.

IBM wanted to use Digital Research's DR-DOS operating system. However, Kildall would not sign IBM's outrageously restrictive non-disclosure agreement and refused to even meet with them. So IBM called Bill Gates again, who immediately recognized the opportunity, purchased the Q-DOS operating system for $50,000 (the Q stands for quick-and-dirty), renamed it MS-DOS, signed IBM's non-disclosure agreement, licensed MS-DOS to IBM, and everyone knows the rest of the story.

There are three important lessons to take away from this tale:

[1] IBM failed to understand that what they thought was most valuable — the hardware — would actually become the least valuable; and what was least valuable — the software — would actually become the most valuable.

[2] Gary Kildall allowed his emotional hatred of the enemy — the evil empire of Big Blue IBM— to overwhelm his rational business senses, which cost him the ultimate prize.

[3] Bill Gates had the common sense to meet with the devil, IBM, on its terms, recognize and seize the opportunity by switching his focus from programming languages to operating systems — and most important of all — he showed-up.

The last great hope for patients, and the physicians who serve them, is for the fate of the U. S. health care system to follow the fate of computing technology. Back in 1980, when the world was dominated by mainframe computers built by IBM, nearly everyone was resigned to the inevitable fact that the power of technology would be increasingly centralized in the hands of governments, and a few select multi-national corporations … just as many people today have resigned themselves to the idea that the U. S. is on the irreversible path towards a single-payer health care system, dominated by governmental agencies, and a few conglomerate hospital systems and third party payers.

However, the history of computing technology did not follow its inevitable path in 1980. A little more than a decade later, the Berlin Wall fell. The Soviet Union disintegrated. And IBM found itself in a crisis for survival, and fired its CEO. Not only had it given away the ultimate prize of software, it was driven out of the hardware business by a college student who started assembling PCs from off-the-shelf parts in his dorm room.

While I'm not so bold to predict that health care will follow the same path as computing technology, reversing its course from centralization to individual patient autonomy, I can easily

envision scenarios of how this can happen, one of which, high-deductible Consumer-Driven Health Plans (CDHP), is growing and evolving at this moment. And what's exciting about this is the fact that today many employers are actively promoting these CDHPs to their workforce, when this was unthinkable a decade ago. So unthinkable, that one well-known U. S. corporation felt compelled to fire the executive responsible for suggesting that its employees should make their own health care decisions.

What's promising about the growing employer movement towards high-deductible CDHP and HSAs is that it's reminiscent of IBM's meeting with Bill Gates a quarter of a century ago. Just as IBM asked Gates help them out because they weren't interested in operating systems, and besides, they weren't very good at them … employers and health plans today are finally forced to admit that they aren't interested in micromanaging the health care of their employees … and besides, they aren't very good at it either.

This is the trend to watch closely, with one caveat. High-deductible health plans and HSAs are meaningless unless employers and health plans back-off, and let patients manage their care, and take control and responsibility for their money. If they insist on micro-managing every transaction below the deductible, they don't grant patients the autonomy to manage their health, and don't grant patients the right to manage their money.

So the moral of the story is: don't be greedy; don't be arrogant; and above all, show up. If the 800 pound health care gorillas ask to meet with you, you may want to take the time to hear their proposal. And if their proposal is something along the line of: we aren't interested in

micromanaging the health care of our employees or members, and besides, we aren't very good at it either. Then I suggest you take careful notes, switch your focus, and take advantage of the opportunity.

But perhaps the best news I can offer is seven years-old. In the 1999 book, *Unleashing the Killer App*, two technology consultants describe how executives at the U. S. Postal Service candidly revealed that they have developed a contingency plan that anticipates a complete shutdown of operations. And the average person can easily understand why. Virtually everything that arrives in your mailbox is either a bill you don't want to pay, or is junk mail advertising you don't want to read. Any message of value arrives to you via e-mail. And any package of value is delivered to you by Fed-Ex or UPS. In other words, the post office can no longer rely on *Gresham's Law* of media for its survival, and its fate is determined by the *Nash Equilibrium*.

What's both truly amazing and enormously reassuring is that the U. S. Postal Service is being driven out of business, despite the fact that it has a monopoly chartered in the U. S. Constitution. Although it's politically impossible to collectively amend the Constitution to break-up the postal monopoly, we are all individually helping to drive the post office out of business by using e-mail, UPS and Federal Express. If the post office is being wiped-out, despite the charter of the 219 year-old Constitution, the future of Medicare — born in 1967 — and HMOs — born in 1973, neither of which require a Constitutional Amendment to repeal, look like terminally ill patients on life-support waiting for someone to pull the plug.