

Correspondence Course

Your May/June 2003 article “All the Actuaries in China” was very enjoyable. You may be interested in knowing that while I was stationed at Kiangwan Air Base (Shanghai) in the spring of 1946 I studied (in off-duty hours) for and took part two (calculus and finite differences) of the old (life) Society of Actuaries exams. (I believe there were 12 parts in those days.) The commanding officer of the 10th Weather Squadron, Col. McCartan, was my superior. He agreed to act as the proctor for the exam and I sat for it in his hotel room at the Broadway Mansions in downtown Shanghai. The good news is that I passed.

Shanghai is 13 time zones ahead of the Eastern time zone. I wondered at the time what the Society could have done about the possibility that someone in my situation might have transmitted the exam questions to the States. I must confess I don't know how they handle that problem today.



The war in the Pacific was over and I was a weather forecaster at the air base—part of the time the station weather officer in charge of the weather station. Among the VIPs I saw coming through Shanghai were Generals Eisenhower and Marshall and Ambassador Harriman. Eisenhower was then Army chief of staff on a world tour of U.S. bases; there was no Defense Department then. Marshall was acting as a liaison in the negotiations between Nationalist China and the Communists. Averell Harriman was flying east

to the States from Moscow where he was ambassador to the Soviet Union.

CHARLES C. HEWITT JR.
NAPLES, FLA.

Son of Section 89

“The Case for Consumer-Driven Health Care” (May/June 2003) was a very interesting article, enlightening as well as disappointing and discouraging.

Is this the best our third-party-payer system can come up with? It's a shame that the third-party payers can't step up to the plate and act in the best interests of their subscribers. I don't believe an individual subscriber is in the best bargaining position when it comes to the important (and lifesaving) medical care benefits!

It appeared to me that David Tuomala missed the point with collectively bargained health care plans, where the active member is responsible for 100 percent of the cost of coverage.

I once had the feeling that health care was the last employee benefit that had little discrimination between the highly compensated and non-highly compensated employees. With consumer-driven plans, I believe that will change as the low-paid get stuck holding the bag with respect to health care costs while the men and women in the corner office are still covered with plans that pay higher benefits. If this is the trend, then a new form of government regulation of discrimination with respect to health care can't be too far behind (“Son-of-Section 89”?). Combining consumer-driven health care plans with the eventual demise of defined benefit plans will, I believe, hasten the di-



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vision of our society into the “haves” and “have-nots.”

I believe that I heard from a session at the enrolled actuaries meeting that in a particular survey, 5 percent of the members accounted for over 53 percent of a particular company's health care costs. Somehow, I believe those 5 percent were unlikely or unable to take the time to shop their health care needs to the lowest cost but highest quality care provider.

MIKE PISULA
PITTSBURGH, PA.

Consumer-Driven Health Care Won't Work

Mr. Tuomala's article on consumer-driven health care in the May/June 2003 issue of *Contingencies* has many assumptions and speculations but very few facts. The most important fact is the double-digit trend. But the premise that the existing system is responsible has not been demonstrated beyond some sketchy anecdotes. Mr. Tuomala references antibi-

otic prescriptions to test viral infections. There are inappropriate treatment patterns and regional variations in clinical practice. But it's unclear whether consumer preference will address this problem or has contributed to it. To understand the psychology for the inappropriate script, just ask any parent with a child who still has a fever of 103 after missing five days of school. It's the very definition of a parent's consumer preference. Will consumer preference on the West Coast be different from the Northeast and increase regional variation?

The argument for consumer preference relies on comparisons with other economic models. But who says that the purchase of cars is efficient? How is efficiency defined? Recently, consumer preference for larger engines and SUVs has decreased the gas mileage of the average American vehicle, hardly in the greater social good. Mr. Tuomala actually references consumerism reducing the impact of managed care. It's ironic that the very consumerism that he advocates has

contributed to the problem.

Another trend driver is our unhealthy lifestyle. Some form of consumerism is needed to address problems like obesity. But the intervention has to occur far in advance of health care delivery. If we get to point of making decisions about diabetes or coronary diagnoses, it's too late. Isn't obesity a consumer preference, at least partly?

Many other drivers of the double-digit trend have been identified, including an antiquated provider infrastructure, malpractice, fraud, an overly complex billing system, a growing uninsured population, inappropriate coverage mandates, and an aging population. It's hard to see how consumer-driven plans would have any effect on any of these.

Consumer-driven concepts have been around for a long time, even before the Clintons and the Jackson Hole think tank. But strict economic analysis misses psychological elements. Are other third-party insurance systems more successful in controlling costs because the psychology is different? There are some incentives that aren't financial, including my life, my health, and the health of my family. Underline the “my” here because of the personal and immediate consequences of decisions. Vision care, fast food, and computers are not purchased under duress and cars are not purchased under the threat of death.

Finally, Mr. Tuomala references the inertial support of existing systems. Yes, I work for an HMO but that doesn't imply a bias toward the existing system, any more than outside consultants are biased toward change for the sake of change.

TONY BATORY
HARTFORD, CONN.

Close, But No Cigar

Uhuru Peak is described (“ACE-ing Kilimanjaro,” May/June) as being “at an elevation of 19,340 feet (more than four miles high).”

It seems to me that four miles is equal to 21,120 feet. You have to be careful with an actuarial audience!

ISIDOR R. STRAUSS
BALTIMORE, MD.

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