employers spend in ways set by legislatures and governors; Medicaid policy is made by the federal government and the states; and policy for Medicare, veterans' benefits, and military dependents is set by the federal government.[6]

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NOTES

1. K. McDonnell and P. Fronstin, *EBRI Health Benefits Databook* (Washington: Employee Benefit Research Institute, 1999), 1. This analysis of the percentage of public spending for health care was stimulated by work conducted by the Milbank Memorial Fund, National Association of State Budget Officers, and the Reforming States Group, *1997 State Health Care Expenditure Report* (New York: Milbank Memorial Fund, 1999). Our alternative estimate for 1997 was based on the sources cited in the *Databook* and below.
2. P.A. Lindsey and J.P. Newhouse, "Summary of a Conference on National Health Expenditure Accounting," *Health Care Financing Review* 7, no. 4 (1986): 91–92; and S.G. Haber and J.P. Newhouse, "Recent Revisions to and Recommendations for National Health Expenditures Accounting," *Health Care Financing Review* 13, no. 1 (1991): 116.
3. Executive Office of the President, Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year* 2000 (Washington: U.S. Government Printing Office, 1999).
4. J. Sheils and P. Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs* (Mar/Apr 1999): 176–181.
5. L.S. Reed and D.P. Rice, "National Health Expenditures: Object of Expenditures and Sources of Funds," *Social Security Bulletin* 27, no. 8 (1964): 12.
6. D.M. Fox, "Strengthening State Government through Managed Care Oversight," *Journal of Health Politics, Policy and Law* 24, no. 5 (1999): 1185–1190.

The 'Right' Accounting Approach: Author's Response

To the Editor:

There is no single "right" accounting framework for measuring health spending. Different frameworks are important for different purposes and can address significant public and private policy issues. However, definitions and treatment of expenditures must be rigorous to ensure unbiased analysis.

HCFA recognizes the value of part of the accounting approach suggested by Dan Fox and Paul Fronstin and has published articles on a similar basis for many years to supplement the usual National Health Accounts (NHA) presentation. (Fronstin recently republished a table from the latest of these articles.)[1] In our articles the NHA "payers" are recategorized as Fox and Fronstin suggest. For consistency, however, we go further, recategorizing private payments made to public programs in a comparable manner. For example, Part B Medicare premiums paid by beneficiaries and the Medicare portion of FICA taxes paid by workers and private employers are reclassified from public to private payments.[2]

Another accounting issue that Fox and Fronstin discuss is the treatment of forgone tax revenues ("tax expenditures"). Fox and Fronstin's treatment, shown in their Exhibit 1, is inappropriate for the NHA framework because it increases total and public payments without any additional health care service or product being purchased.[3] This addition to expenditures would create payments to the health care industry greater than the services and products purchased and would throw the NHA accounting framework out of balance. In the end, while the rhetorical use of the term *tax expenditures* emphasizes the cost of targeted deductions in lost government tax revenue, this practice is not synonymous with actual government spending and should not be defined as such in the NHA.

However, although it is not appropriate to count forgone taxes as expenditures, it is certainly correct to surmise that public policy does influence individuals' and employers' health insurance purchasing decisions. Our *Health Affairs* paper discusses issues of this type that are not suitable to include in our accounting framework. We appreciate the reminder to present this issue in future papers.

I also wish to correct Fox and Fronstin's misunderstanding about recommendations made by independent expert panels periodically convened to examine NHA methods,

data sources, and accounting issues. We give serious consideration to these recommendations and, as resources permit, adopt many of them. No panel has suggested that forgone tax revenues be included in the NHA, or that we are remiss in presenting alternative payer accounting frameworks. Instead, one panel of experts concluded that estimates of tax financing of insurance premiums were available from the Congressional Budget Office (CBO), and "it is not clear that HCFA needs to play any additional role."[4] Another panel recommended that we continue to reclassify payers as an adjunct to the usual NHA presentation but that we do so more frequently (on an annual rather than intermittent basis).[5]

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NOTES

1. K. McDonnell and P. Fronstin, *EBRI Health Benefits Databook* (Washington: EBRI, 1999), 27.
2. For a complete discussion of these adjustments, see K. Levit, M. Freeland, and D. Waldo, "Health Spending and Ability to Pay: Business, Individuals, and Government," *Health Care Financing Review*5 (Spring 1989): 1–11. Additional updates were published in the *Health Care Financing Review*, Winter 1990, Winter 1991, Summer 1993, Summer 1996, and Spring 1997 issues. Publication of this article will resume this year. Preparation of these estimates was suspended in 1997, in part because of the lack of availability of reliable information on employer- and employee-paid private health insurance premiums.
3. Technical experts on U.S. national income accounting, and the System of National Accounts endorsed by the United Nations and five other international organizations, do not count imputed flows of tax expenditures in any recognized national income accounting framework.
4. Although the CBO does not produce estimates of forgone tax revenue, they are available in Office of Management and Budget, *Analytical Perspectives of the Budget of the United States, Fiscal Year 2000* (Washington: U.S. GPO, 1999), 107. Also, see P.A. Lindsey and J.P. Newhouse, "Summary of a Conference on National Health Expenditures Accounting," *Health Care Financing Review* (Summer 1986): 92.
5. S.G. Haber and J.P. Newhouse, "Recent Revisions to and Recommendations for National Health Expenditures Accounting," *Health Care Financing Review* (Fall 1991): 116.

Role Of Retiree Benefits In Health Insurance's Future

To the Editor:

The issue of *Health Affairs* on the future of health insurance (Nov/Dec 99) included a number of interesting papers on the employer-based system but did not address key trends in employer-sponsored retiree coverage. Such trends are a key piece of the future, particularly with respect to the integration of employer-sponsored plans with proposed Medicare reforms and proposals to expand Medicare prescription drug coverage.

Consider these observations drawn from a recent report prepared for the Henry J. Kaiser Family Foundation by Hewitt Associates (*Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, October 1999): (1) Employer-based plans are the largest source of supplemental coverage and prescription drug coverage for Medicare-eligible retirees. (2) Large employers (those with 1,000 or more employees) continue to provide retiree health coverage at levels that far exceed those of smaller employers. These large employers are the most likely to offer retiree health coverage. (3) Fewer large employers are providing retiree coverage. Between 1991 and 1998 the percentage of employers in the Hewitt database of more than 1,000 large companies that provide retiree health benefits declined by twelve to thirteen percentage points. The immediate impact on retirees is generally limited: Most large employers that drop retiree health coverage do so on a prospective basis—that is, for new hires after a certain date. The main effects will be felt in the future and reflected in less supplemental coverage.

(4) Where employers retained coverage, retiree premiums were added or increased, cost sharing increased, and eligibility tightened. Often, but not always, existing retirees were grandfathered. Large employers also moved to offer managed care for retirees. The rapid growth in large-employer sponsorship of Medicare managed care plans took place between 1993 and 1996; since then, growth in sponsorship has been slow. In part, the slow-

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