

---

# LETTERS

**W**e welcome your responses to papers that appear in *Health Affairs*. Please keep your comments brief (300–500 words) and sharply focused. *Health Affairs* reserves the right to edit all letters for clarity and length. *Health Affairs* will not acknowledge receipt of unsolicited letters that are not published. Letters can now be submitted via e-mail ([healthaffairs@projhope.org](mailto:healthaffairs@projhope.org)) or the *Health Affairs* Web site ([www.projhope.org/HA](http://www.projhope.org/HA)).

## **PBMs: A Key Player In Medicare Drug Coverage**

To the Editor:

Prescription drugs have become increasingly important weapons in physicians' treatment arsenal, a trend that surely will continue. Correspondingly, drug spending has increased at a pace that far exceeds the medical Consumer Price Index (CPI). Indeed, a recent study by Express Scripts indicated that costs per covered person grew 16.8 percent in 1998; drug costs will likely double over the next five years.

Medicare beneficiaries—the elderly and disabled—are the people most affected by these alarming cost trends. The confluence of rising costs, and what John Rother of AARP argued here in *Health Affairs* (“A Drug Benefit: The Necessary Prescription for Medicare,” July/Aug 99) is a growing number of under- or uninsured senior citizens, could compromise the quality of care provided to the elderly. Bringing Medicare up to date by including prescription drugs as a universally covered Medicare benefit is a major step forward.

The key issue is how this benefit can be provided in a cost-effective manner that promotes appropriate prescription drug use. In the same issue of *Health Affairs* Lynn Etheredge proposed that private-sector health care delivery mechanisms, including pharmacy benefit managers (PBMs), be used to deliver drugs to beneficiaries (“Purchasing Medicare Prescription Drug Benefits: A New Proposal”).

We believe that PBMs can play a major role in terms of (1) purchasing prescription

drugs at discounted rates from retail pharmacies; (2) providing discounted, convenient prescriptions via mail service to promote better compliance with medication regimens; (3) negotiating volume discounts from pharmaceutical manufacturers; (4) developing and maintaining clinically valid formularies to promote the use of cost-effective medications; (5) enhancing quality of care through point-of-sale clinical audits, retrospective utilization review, and clinical program interventions tailored to the elderly; (6) offering health information to seniors via telephone and the Internet; (7) giving seniors choice in formulary and benefit design; and (8) facilitating electronic prescribing by physicians to improve formulary compliance and to reduce medical errors.

As federal officials debate the future shape of Medicare prescription drug coverage, we hope that these deliberations will recognize the vital role of the private sector. In particular, PBMs, either as subcontractors to Medicare+Choice and Medigap plans or as contractors to employers and the federal government, can be a positive force.

The industry's promise in this area can best be fulfilled if the federal government refrains from imposing rigid rules for PBMs. There are several constructive options. First, any law establishing a Medicare prescription drug benefit should require that the program be administered by established, reputable PBMs that will operate according to the industry's best practices and without bias. Second, the government rightly should protect the public from inappropriate behavior by PBMs and other providers, but it should do so by focusing on results, not by specifying every operational and financial feature up front. Third, the program should reward providers for achieving agreed-upon goals for cost, clinical quality, and patient satisfaction.

BARRETT A. TOAN

EXPRESS SCRIPTS

MARYLAND HEIGHTS, MISSOURI

## Patient Education And Protection Through PBMs

To the Editor:

Lynn Etheredge's paper provides an excellent overview of the key issues involved in the design and management of a Medicare prescription drug benefit. PCS Health Systems believes that the elderly population not covered by a drug benefit management program would benefit enormously from the type of PBM administration that has evolved in the private sector. PBMs can provide the elderly—who make up 13 percent of the population but use 30 percent of all outpatient prescription drugs—with drug-use management and education programs. Such programs are vital to a population at risk for hospitalization as a result of drug interactions. Increasingly, PCS and other PBMs look at drug management as a part of overall medical care.

PBMs also would bring savings to a Medicare drug benefit. In 1997 the U.S. General Accounting Office studied the savings PBMs produced for the Federal Employees Health Benefits Program (FEHBP) and found savings of 20–27 percent, relative to what would have been spent without PBMs. We believe that even greater savings are possible.

PBMs will improve overall health care management, especially for Medicare beneficiaries with the highest drug and medical spending—the 5 percent who account for 16 percent of all over-age-sixty-five drug spending. PCS's high-risk/high-cost population management programs link medical and drug information, under strict privacy and confidentiality protections. Such linkages can create significant savings in medical costs for patients with cardiovascular disease, diabetes, and asthma, among others.

As Etheredge argues, for PBMs to be most effective, a Medicare drug benefit should be structured to allow the competitive process to operate freely, to preserve the current best practices among PBMs, and to allow them to continually innovate and improve. As new drugs appear, with new clinical profiles, it is essential that PBMs be encouraged to evolve

design incentives, utilization management programs, and provider selection practices.

For these reasons, we agree with Etheredge on the types of risk and accountability that should be part of any program. PBMs should compete on the basis of drug management successes; the ability to reduce excess, inappropriate, and sometimes dangerous utilization; and the opportunity to support physicians with essential information, to educate and reinforce patient compliance and drug education and to create high-quality pharmacy networks that offer the most cost-effective dispensing and the most effective patient and physician information.

ELIZABETH DICHTER  
PCS HEALTH SYSTEMS INC.  
SCOTTSDALE, ARIZONA

## Public Spending For Health Care Approaches 60 Percent

To the Editor:

Katharine Levit and colleagues underestimate public expenditures for health care in "Health Spending in 1998: Signals of Change" (Jan/Feb 00). They assert that the public-sector share of total spending in 1998 was 45.5 percent, down from 46.2 percent in 1997. Before this paper was published, we estimated that public spending accounted for 58 percent of total health spending in 1997.<sup>1</sup> Using data from Levit and colleagues, we now revise our 1997 estimate to 57 percent and estimate public spending in 1998 at 56 percent (Exhibit 1).

The substantial difference between the federal government numbers and our estimates is a result of decisions about methodology made during the past four decades by the Health Care Financing Administration (HCFA) and its predecessor agencies. Eminent economists convened by HCFA twice unsuccessfully challenged these decisions.<sup>2</sup>

Our analysis uses two sets of data in different ways than HCFA does. The first set derives from the Budget Act of 1974 (P.L. 93-344), which defined as public expenditures tax collections forgone as a result of health and social policy carried out through tax law. Each year the Treasury Department estimates

**EXHIBIT 1****National Health Expenditures, By Source Of Funds, Amounts, And Distribution, HCFA And Alternative Estimates For 1998**

Source of funds	Total spending (billions)		Percent distribution	
	HCFA estimate	Alternative estimate	HCFA estimate	Alternative estimate
National health expenditures	\$1,149.1	\$1,273.9	100%	100%
Private funds	626.4	563.1	55	44
Consumer payments	574.5	511.3	50	40
Out-of-pocket payments	199.5	199.5	17	16
Private health insurance	375.0	311.8	33	24
Other private funds	51.8	51.8	5	4
Public funds	522.7	710.7	45	56
Federal	376.9	389.3	33	31
Medicare	216.6	216.6	19	17
Medicaid	100.3	100.3	9	8
Other federal	60.0	72.4	5	6
State and local	145.8	196.5	13	15
Medicaid	70.3	70.3	6	6
Other state and local	75.5	126.2	7	10
Tax expenditures	0.0	124.8	0	10

**SOURCE:** K. Levit et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124-132; and authors' estimates.

**NOTE:** HCFA is Health Care Financing Administration.

the amount of taxes uncollected as a result of policy, as well as how much direct federal spending would be required to purchase the same quantity of services. Tax expenditures for health care now exceed those for pensions or mortgage subsidies. Treasury estimates an outlay equivalent in direct federal spending of \$575 billion through 2004.<sup>3</sup> A recent paper in *Health Affairs* estimated 1998 tax expenditures for health by all levels of government at \$124.8 billion.<sup>4</sup>

The second difference is that the numbers we report count spending for health coverage for public employees as a public-sector expense. HCFA and its predecessors have assigned this spending to the private sector since at least 1964, when federal statisticians reasoned that insurance offered by private and public employers was a "form of compensation to employees and not an expenditure...for health care."<sup>5</sup>

This reasoning may have been appropriate for a time when private and public employers transferred all group payment for health care

to insurance carriers, which then made every pertinent decision about reimbursing providers on a cost or cost-plus basis. During these years, moreover, advocates of national health insurance within the federal government were often eager to emphasize evidence of low public spending for health care in the United States in comparison with that of other industrial countries.

The assumption that the active purchase of health care for public employees, paid from taxes, is a private-sector expense is illogical. Such a characterization makes no more sense than does describing Medicaid contracts with health maintenance organizations (HMOs) as private-sector spending. Indeed, the substantial spending for public employees' benefits would reduce the estimated incremental costs of a national health plan.

All health care purchases, except for consumers' decisions about out-of-pocket spending, are made using funds that are strongly linked to public policy. Private employers spend money excluded from taxation; public

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.<sup>6</sup>

DANIEL M. FOX

MILBANK MEMORIAL FUND

NEW YORK, NEW YORK

PAUL FRONSTIN

EMPLOYEE BENEFIT RESEARCH INSTITUTE

WASHINGTON, D.C.

## 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, defini-

tions 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.)<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup> 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."<sup>4</sup> 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).<sup>5</sup>

KATHARINE LEVIT  
HCFA OFFICE OF THE ACTUARY  
BALTIMORE, MARYLAND

#### 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-

down is attributable to the disruption in the Medicare+Choice market in the aftermath of changes from the Balanced Budget Act (BBA), and it may continue to slow because of steep premium increases in 2000.

The first wave of employer modifications came in response to a change in the accounting rules (FAS 106) that most companies had to adopt by 1993. These new rules increased employers' costs by requiring that retiree health benefits be measured on an accrual basis, not the previous pay-as-you-go approach. But recent data indicate that employer adjustments will continue into 2000.

In a 1999 survey of 600 large employers, Hewitt asked which changes in age-sixty-five-plus retiree health coverage these employers would "seriously consider" in the next three to five years: (1) 81 percent would consider increasing premiums and cost sharing for retirees; (2) 53 percent would consider shifting to a defined-contribution approach and allowing retirees to purchase their own coverage; (3) 50 percent would consider only offering managed care as an option, while 50 percent said that they would not; (4) 40 percent would consider cutting back on prescription drug coverage for retirees; (5) 30 percent would consider prospectively terminating retiree coverage; and (6) 17 percent would consider adding to or improving coverage for retirees.

Given the important role that employer-sponsored coverage plays in providing supplemental and prescription drug coverage for retirees, the debate over proposals to reform Medicare should pay careful attention to the interactive effects. Depending on future public policy, the gradual decline in retiree coverage could either be accelerated or slowed. And in the marketplace, we may see the emergence of intermediaries responding to the increased demand for health insurance on the part of retirees who lack employer coverage or who want a greater choice of options.

FRANK McARDLE

HEWITT ASSOCIATES LLC

WASHINGTON, D.C.

## **Taking A Giant Leap Forward In Promoting Quality**

To the Editor:

The November/December 1999 issue of *Health Affairs* focused needed attention on the future of our employer-based health care system. One paper ("An Employer's View of the U.S. Health Care Market") referred to a newly formed group calling itself "Leapfrog." This group of major employers and coalitions has as its charter to strengthen the role of the nation's employer-purchasers in addressing high-quality, affordable health care for all.

There is an abundance of evidence that quality, safety, and cost in the health care industry fall short of the best that is achievable. As a consequence, we have needlessly high levels of illness and death from preventable causes, growing dissatisfaction with health care, and a cost structure that leaves U.S. employers less competitive in the global economy. We as purchasers have the potential to drive change by rigorously identifying and rewarding superior health care value.

The Leapfrog group has written an "operational blueprint" to unite purchasers in the pursuit of an improved U.S. health care system. The Business Round Table has agreed to put the blueprint into place. The blueprint contains the following seven points: (1) Develop, disseminate, and steadily elevate a set of common purchasing principles designed to strongly incent superior health care value. Empowering employees as consumers with good information can be a powerful motivating force. (2) Subscription to purchasing principles will be voluntary, documented by completion of a checklist, propagated by social norms among purchasers analogous to subscription to ISO 9000 manufacturing norms. (3) Purchasing principles will be flexible to accommodate member differences in geographic, demographic, organizational, and market structures. (4) Purchasing principles will be structured in stepwise fashion, so that purchasers can benchmark themselves against the most exacting standard and ascertain how they can advance.

(5) In partnership with the health care industry, select for special focus the rapid, industrywide adoption of two to four discrete improvements (“safety leaps”) likely to yield the largest gain in patient safety. (6) Transform these discrete improvements and their corresponding dangers into simple, compelling concepts that will “stick” in the awareness of all stakeholders (for example, hospitals without computerized physician order entry are unnecessarily risky). (7) Use the public stature of the Business Round Table and contacts of the founding purchasers to catalyze wide adoption of the purchasing principles by other purchasers and establish the concepts in the common language of the American people.

Through such focused, organized efforts, we hope to take advantage of our position as leaders in American industry to encourage the changes to our system that are long overdue.

STEVEN WETZEL  
BUYERS HEALTH CARE ACTION GROUP

ROBERT GALVIN AND CHARLES R. BUCK JR.  
GENERAL ELECTRIC

JAMES CUBBIN AND BRUCE BRADLEY  
GENERAL MOTORS CORPORATION

BRUCE TAYLOR  
GTE CORPORATION

PATRICIA POWERS AND ARNOLD MILSTEIN  
PACIFIC BUSINESS GROUP ON HEALTH

### **Why Is The Cost Of FEHBP Coverage So Low?**

To the Editor:

Steve Long and Susan Marquis (“Comparing Employee Health Benefits in the Public and Private Sector,” Nov/Dec 99) confirm the finding that the value and resulting cost of the FEHBP is well below the average of plans offered to public and private employees. The reason, which Long and Marquis do not mention, has been explained numerous times: FEHBP dental benefits are low compared with similar benefits in other large employers’ health plans. Thus, the total FEHBP benefit

package is below average.

The reason is tied to the history of the FEHBP. In the early 1970s, when only one or two FEHBP plans had added dental benefits, the federal government adopted a policy of not permitting plans to improve benefits without offsetting cutbacks. During the 1970s and 1980s, when most employers were adding good dental benefits, the FEHBP plans could not find the cutbacks necessary to offer a meaningful dental program. The result is dental benefits that only provide a nominal portion of dental expenses.

EDWIN C. HUSTEAD  
HAY GROUP  
ARLINGTON, VIRGINIA

### **Reliable Premium Payers**

To the Editor:

I read Uwe Reinhardt’s paper, “Employer-Based Health Insurance: A Balance Sheet” (Nov/Dec 99), with great interest. One of the attributes of employer-based coverage that I didn’t find in his analysis (nor in any of the related papers) is the fact that employers are reliable payers of premiums. If there were a shift toward replacing employer-based coverage with individual policies, one might wonder how reliable those individuals would be as premium payers. Healthy but financially strapped individuals could neglect to pay their premiums. And given the limitations on reentering coverage, I fear that this would lead to a rise, not a decline, in the number of uninsured persons in this country.

JIM SCHWARTZ  
ALLIANCE EMPLOYEE HEALTH ACCESS INC.  
TOPEKA, KANSAS

### **Doctors’ Fears Of Fraud**

To the Editor:

Andrew Batavia’s unfortunate experiences in his attempt to acquire a new wheelchair (“Of Wheelchairs and Managed Care,” Nov/Dec 99) mentions but does not emphasize the likely reason his doctor would not write the prescription. The doctor was probably afraid of being prosecuted for fraud. This threat is a powerful disincentive to proper pa-

tient advocacy.

There is much publicity about federal investigation and prosecution of doctors for technical violations of the law. Any rational solution to the problem of durable medical equipment (DME) must provide appropriate immunity to doctors who prescribe DME in good faith for the welfare of their patients.

HERBERT RAKATANSKY

BROWN UNIVERSITY

PROVIDENCE, RHODE ISLAND

## Emergency Care As Safety Net

To the Editor:

The hospital emergency department is perhaps the only unrestricted site of universal health care in America, a fact that is often understated in discussions about the safety net (Larry Gage and Marsha Regenstein, "Bolstering the Safety Net," Sep/Oct 99).

Visits to U.S. emergency rooms have risen to more than ninety million per year. Managed care has not had the expected impact on emergency department use.<sup>1</sup> Even improved access to primary care has not eliminated preferential emergency department use among the disadvantaged.<sup>2</sup> More and more of the country's uninsured persons may be forced to seek care there as community clinics founder in an increasingly competitive health care marketplace.

Welfare reform may have an even greater impact. Medicaid benefits are now denied to new legal immigrants for at least five years, regardless of age, health, disability, or work status. While the new legislation denies or reduces food assistance, welfare payments, disability income, and health insurance, it makes one curious exception: "No state may deny coverage of emergency medical services to either illegal or legal aliens."<sup>3</sup> Just as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 singled out the emergency department as the only component of the medical system required to provide services, it is now identified as the only component of the welfare system protected by law.

Because of its position at the interface of

health and welfare, the emergency department can help to bridge the gaps among medicine, public health, and social work, especially as collaboration enhances the success of Medicaid managed care initiatives. Pilot programs for primary care referral and follow-up, and for coordination of preventive public health and social services, have been particularly promising among disadvantaged populations using emergency departments.<sup>4</sup> Moreover, the costs of emergency care, especially for non-urgent problems, are less than believed.<sup>5</sup>

While the viability of many safety-net providers is threatened under health and welfare reform, emergency departments have become an expected, guaranteed entity. Most communities will continue to support an emergency department as the local provider of last resort, regardless of the prevailing reform scenario. The nature and scope of that support, however, will shape the kinds of contributions the department can make to an integrated health care marketplace.

JAMES A. GORDON

MASSACHUSETTS GENERAL HOSPITAL

BOSTON, MASSACHUSETTS

## NOTES

1. J.E. Sisk et al., "Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use," *Journal of the American Medical Association* 276 (1996): 50-55.
2. R.F. St. Peter, P.W. Newacheck, and N. Halfon, "Access to Care for Poor Children: Separate and Unequal?" *Journal of the American Medical Association* 267 (1992): 2760-2764.
3. *Personal Responsibility and Work Opportunity Reconciliation Act of 1996: An Analysis Prepared by the American Public Welfare Association, the National Governors' Association, and the National Conference of State Legislatures* (22 August 1996), 12.
4. J.A. Gordon, "The Hospital Emergency Department as a Social Welfare Institution," *Annals of Emergency Medicine* 33 (1999): 321-325.
5. R.M. Williams, "The Costs of Visits to Emergency Departments," *New England Journal of Medicine* 334 (1996): 642-646.

## Erratum

In Exhibit 3 of "Health Spending in 1998: Signals of Change" (Jan/Feb 00, page 127), the reference "b" was inadvertently dropped. Its value is \$60.8 billion.