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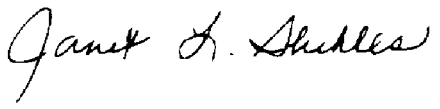
Preface

The General Accounting Office (GAO), an arm of the Congress, was established to independently audit government agencies. GAO's Health, Education, and Human Services (HEHS) Division reviews the government's health, education, employment, social security, welfare, and veterans programs administered in the Departments of Health and Human Services, Labor, Education, Veterans Affairs, and some other agencies.

This booklet lists the GAO products issued on these programs. It is divided into two major sections:

- Most Recent GAO Products: This section identifies reports and testimonies issued during the past 5 months and provides summaries for selected key products.
- Comprehensive 2-Year Listings: This section lists all products published in the last 2 years, organized chronologically by subject as shown in the table of contents. When appropriate, products may be included in more than one subject area.

You may obtain single copies of the products free of charge, by telephoning your request to (202) 512-6000 or faxing it to (301) 258-4066. Additional ordering details, as well as instructions for getting on our mailing list, appear at the end of this booklet.



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Contents

Abbreviations

ADP	automatic data processing
AFDC	Aid to Families With Dependent Children
ADEA	Age Discrimination in Employment Act of 1967
AIDS	acquired immunodeficiency syndrome
AoA	Administration on Aging
BOP	Bureau of Prisons
CalPERS	California Public Employees' Retirement System
CDC	Centers for Disease Control and Prevention
CDR	continuing disability review
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRS	Congressional Research Service, Library of Congress
CPA	Certified Public Accountant
DA&A	drug addiction and alcoholism
DC	District of Columbia
DDS	disability determination services
DI	Social Security Disability Insurance
DOD	Department of Defense

DODDS	Department of Defense Dependents Schools
DOE	Department of Energy
EDA	Education and Deaf Act of 1986
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
EPA	Environmental Protection Agency
ERISA	Employee Retirement Income Security Act of 1974
ESEA	Elementary and Secondary Education Act
FDA	Food and Drug Administration
GAO	General Accounting Office
GSA	General Services Administration
HEAF	Higher Education Assistance Foundation, Department of Education
HEHS	Health, Education, and Human Services Division, GAO
HCFA	Health Care Financing Administration
HealthPASS	Philadelphia Accessible Services System
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRD	Human Resources Division, U.S. General Accounting Office
HUD	Department of Housing and Urban Development
INS	Immigration and Naturalization Service
IHS	Indian Health Service
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JOBS	Job Opportunities and Basic Skills program
JTPA	Job Training Partnership Act
LEP	limited English proficient
MSA	metropolitan statistical area
MTS	Medicare Transaction System
NAGB	National Assessment Governing Board, Department of Education
NTID	National Technical Institute for the Deaf
OIG	Office of Inspector General
OPM	Office of Personnel Management
OSHA	Occupational Safety and Health Administration
QMB	Qualified Medicare Beneficiary
PBGC	Pension Benefit Guarantee Corporation
PHS	HHS Public Health Service

PATH	Projects for Assistance in Transition from Homelessness
RBRVS	Medicare Resource-Based Relative Value Scale
RFP	Request for proposals
SSA	Social Security Administration
SSI	Supplemental Security Income
TAA	Trade Adjustment Assistance
TQM	total quality management
UI	unemployment insurance
USDA	United States Department of Agriculture
USPS	United States Postal Service
VA	Department of Veterans Affairs
WARN	Worker Adjustment and Retraining Notification Act
WIC	Special Supplemental Food Program for Women, Infants, and Children

Most Recent GAO Products (December 1993 - April 1994)

Health

Selected Summaries

Long-Term Care Reform: Program Eligibility, States' Service Capacity, and Federal Role in Reform Need More Consideration (Testimony, 4/14/94, GAO/T-HEHS-94-144).

Demographic pressures, rising expenditures, and dissatisfaction with services provide a compelling rationale for long-term care reform. There are several legislative proposals that seek to either improve existing federal long-term care programs, create new programs, or expand the role of the private sector. Passage of any long-term care reform legislation is the first step of a long process and not the final word on how the nation meets long-term care needs. This legislation would require a different federal role, largely one of partnership with the states in the design, administration, and monitoring of programs. If the Health Security Act is passed, additional consideration should be given regarding the federal government's role specifically as well as better guidance to the states on eligibility determination and how states with less capacity can be assisted in wisely using program funds.

Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (Report, 4/13/94, GAO/HEHS-94-71).

Although recent publicity has raised questions about the financial condition of Blue Cross/Blue Shield plans, 53 of 64 plans are rated in fair to excellent financial condition by Weiss Research. The remaining 11 plans, which insure about one-fourth of all Blue Cross/Blue Shield subscribers, are rated in weak to very weak financial condition because of several factors. Mismanagement contributed to the financial weaknesses of some plans. In addition, weaknesses in the oversight roles played by plan boards of directors and state regulators allowed plans' financial problems to persist. The Blue Cross and Blue Shield Association, individual plans, and states have acted to remedy the problems of financially troubled plans. Health care reform could significantly affect Blue Cross/Blue Shield plans and commercial insurers by altering the competitive nature of the health insurance market.

Long-Term Care: Demography, Dollars, and Dissatisfaction Drive Reform (Testimony, 4/12/94, GAO/T-HEHS-94-140).

The current long-term care system has been patched together from multiple funding streams, both federal and state. Individuals seeking services often have to contend with a fragmented service delivery system that forces them to negotiate for services from a variety of agencies. Approximately 11 million Americans of all ages are chronically disabled and depend on others for assistance in the basic tasks of daily living. Unprecedented growth in the elderly population is projected for the 21st century, and the population aged 85 and over is expected to outpace the rate of growth for all elderly aged 65 and over. Current government spending of about $70 billion is expected to rise, yet the long-term care system is fragmented, does not meet current demand, and is not well matched to the diverse needs of individuals. GAO suggests two principles to consider in long-term care deliberations: (1) greater tailoring of services to the needs of the individual and (2) greater flexibility in funding.

Health Care Alliances: Issues Relating to Geographic Boundaries (Report, 4/8/94, GAO/HEHS-94-139). Testimony on same topic (2/24/94, GAO/T-HEHS-94-108).

A common feature of many health reform bills is the creation of public or private health purchasing groups, known as alliances. The alliances have been proposed mainly as a way to broaden coverage, pool risks, give consumers a choice of health care plans, and disseminate information on the costs and quality of plans. The major health reform proposals relying on alliances, however, have boundary provisions that raise concerns. These concerns include the potential for gerrymandering, changing the provision and receipt of health care, segmenting high-risk groups, and isolating underserved areas.

Health Care in Hawaii: Implications for National Reform (Testimony, 3/16/94, GAO/T-HEHS-94-123). Report on same topic (2/11/94, GAO/HEHS-94-68).

Hawaii has the highest level of insurance coverage of any state in the nation. Hawaii's residents lacking health insurance in 1991 ranged from an estimated 3.75 to 7.0 percent in comparison with the national average of 14 percent. Nevertheless, Hawaii's employer mandate and government programs do not ensure coverage for everyone in the state. Further, even some residents with insurance encounter problems obtaining access to health services and need community health centers and other safety net programs. Hawaii has experienced the same trend of rising costs as the rest of the nation. Although Hawaii has a requirement that employers

provide health insurance, large disruptions in Hawaii's small business sector have not resulted.

Long-Term Care: Support for Elder Care Could Benefit the Government Workplace and the Elderly (Report, 3/4/94, GAO/HEHS-94-64).

Currently, about 2 million working Americans, including government employees, are providing significant unpaid care to elderly relatives in the community who need help with everyday activities. Work and family responsibilities often conflict for caregivers living near or far from their disabled elderly relatives. Federal, state, and city governments with the largest workforces that GAO studied offer flexible schedule options and elder care information. Providing elder care information in the workplace is less common because elder care has only recently become recognized as a workplace issue. Office of Personnel Management (OPM) efforts to promote elder care at the federal level are a good start. It is too early, however, to evaluate the effectiveness of OPM's efforts.

Medicare: Greater Investment in Claims Review Would Save Millions (Report, 3/2/94, GAO/HEHS-94-35).

Between January 1989 and September 1991, the Health Care Financing Administration (HCFA) conducted a study to determine whether giving carriers greater management discretion over medical review, as well as additional funding, would result in program improvements. The study involved five carriers: three carriers (referred to as demonstration carriers) were given added management flexibility and funding, and two carriers continued performing medical review operations with no modifications to their medical review process and funding. The demonstration carriers intensified efforts to identify unusual spending patterns and trends. These efforts netted increased savings, making the greater funding of medical review activities worthwhile. With additional resources, they were able to focus on examining spending data for individual procedures.

Bureau of Prisons Health Care: Inmates' Access to Health Care Is Limited by Lack of Clinical Staff (Report, 2/10/94, GAO/HEHS-94-36).

Inmates with special needs, including women, psychiatric patients, and patients with chronic illnesses, were not receiving all of the health care they needed at the three medical referral centers we visited. There were insufficient numbers of physician and nursing staff to perform required clinical and other related tasks. While the centers had quality assurance programs, two of the centers failed to correct identified quality assurance problems. Physicians at each of the centers were qualified to perform the work they were assigned. However, many physician assistants did not meet training and certification requirements of the medical community outside Bureau of Prisons (BOP). To reduce its reliance on community hospitals, BOP is considering constructing six large acute tertiary care hospitals, acquiring several military facilities, or both. BOP needs to determine its basic requirements and consider the costs and benefits of other alternatives before proceeding with the construction or acquisition of facilities.

Managed Health Care: Effect on Employers' Costs Difficult to Measure (Testimony, 2/2/94, GAO/T-HEHS-94-91). Report on same topic (10/19/93, GAO/HRD-94-3).

Although many employers believe that, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care. Most studies that compare firms' health care costs for employees under managed care to those under indemnity plans do not adequately control for key factors affecting cost, such as employees' age or health status. Some managed care plans have a potential for cost savings. Restrictions on employee choice of health care provider is viewed as the major constraint on employee acceptance of network-based managed care plans. Increasingly, employers are taking steps to address the need for adequate information on health plans' costs and quality.

Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (Report, 1/31/94, GAO/HEHS-94-60).

About 2 million working Americans are providing significant unpaid care to their elderly relatives, who live in the community and need assistance with everyday activities. An additional 6 million employed persons have disabled parents or spouses who may also need assistance with these activities. The number of employed caregivers is expected to grow as the population ages. Work and family responsibilities often conflict, and many

caregivers provide assistance long distance. Companies' support for their employed caregivers could be strengthened if managers identified and actively supported the use of flexible working schedule options for elder care. Caregivers struggling to balance work and family responsibilities may find useful company services that offer them flexible schedules and needed information, while employers may see reduced work disruption, such as turnover and absenteeism. Employer-sponsored elder care can also benefit the elderly persons being helped.

Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (Report, 1/20/94, GAO/HEHS-94-52).

Families USA's 1993 national estimate that 1.8 million senior citizens were eligible for but not enrolled in the Qualified Medicare Beneficiary (QMB) program is a reasonable estimate. Federal and state governments have taken a number of actions to alert potentially eligible people about the program. The reasons cited by federal and state officials for more people not enrolling include (1) eligible people perceiving a welfare stigma attached to the program, (2) the complicated application process, and (3) eligible people believing that the benefit of enrolling is not worth much in monetary terms. One action proposed to increase enrollment is to authorize the Social Security Administration (SSA) to determine QMB eligibility. SSA has opposed this option for a number of reasons, including insufficient resources to carry out the function.

Prescription Drugs: Companies Typically Charge More in the United States Than in the United Kingdom (Report, 1/12/94, GAO/HEHS-94-29).

We found significant differences in the prices that manufacturers charge wholesalers for identical, frequently dispensed prescription drugs sold in retail pharmacies in the United States and the United Kingdom. A market basket of 77 frequently dispensed drugs that we analyzed would cost wholesalers 60 percent more in the United States than in the United Kingdom. Price differentials tended to be dramatically smaller for more recently introduced drugs in our sample than for older products. Price differentials tended to be smaller for single-source brand-name drugs in our sample than for brand-name drugs that have generic substitutes. We found that U.S.-U.K. drug price differences are primarily due to the regulatory constraints that manufacturers face in pricing their drugs on the U.K. market and to the lack of similar constraints in the United States.

Drug Use Among Youth: No Simple Answers to Guide Prevention (Report, 12/29/93, GAO/HRD-94-24).

While fewer adolescents report alcohol and illicit drug use in current surveys than in past years, adolescents still report use. Alcohol remains the drug of choice among adolescents, with more than 57 percent of high school seniors reporting current use. Our analysis of the National Longitudinal Survey of Youth identified some risk factors. Risk factor research reveals no simple answers to explain why young people use alcohol and/or drugs. Neither our work nor other research done on risk factors to date can provide answers for the optimum mix of prevention programs and strategies.

Other Health Products

Public Health Services: Agencies Use Different Approaches to Protect Public Against Disease and Injury (Report, 4/29/94, GAO/HEHS-94-85BR).

Health Care: Antitrust Enforcement Under Maryland Hospital All-Payer System (Report, 4/27/94, GAO/HEHS-94-81).

Medicare: Impact of OBRA 90's Dialysis Provisions (Report, 4/25/94, GAO/HEHS-94-65).

Medicare Transaction System (Letter, 4/20/94, GAO/HEHS-94-143R).

Medicare: Beneficiary Liability for Certain Paramedic Services May Be Substantial (Report, 4/15/94, GAO/HEHS-94-122BR).

Health Care Quality: How Does the United States Compare With Other Countries on Cancer Survival and Access to Bone Marrow Transplantation? (Testimony, 4/14/94, GAO/T-PEMD-94-21).

Long-Term Care: The Need for Geriatric Assessment in Publicly Funded Home and Community-Based Programs (Testimony, 04/14/94, GAO/T-PEMD-94-20).

Medicare Diagnostic Imaging Rates (Letter, 4/5/94, GAO/HEHS-94-129R).

Medigap Loss Ratios, First 2 Years (Letter, 4/4/94, GAO/HEHS-94-131R).

Long-Term Care: Status of Quality Assurance and Measurement in Home and Community Based Services (Report, 3/31/94, GAO/PEMD-94-19).

Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers (Testimony, 3/29/94, GAO/T-PEMD-94-17).

Los Angeles County Medi-Cal (Letter, 3/18/94, GAO/HEHS-94-116R).

Health Care Reform: How Proposals Address Fraud and Abuse (Testimony, 3/17/94, GAO/T-HEHS-94-124).

Cancer Survival: An International Comparison of Outcomes (Report, 3/7/94, GAO/PEMD-94-5).

Bone Marrow Transplantation (Report, 3/7/94, GAO/PEMD-94-10).

Medical Review Saving (Letter, 2/28/94, GAO/HEHS-94-93R).

Medical Malpractice Insurance Options (Letter, 2/28/94, GAO/HEHS-94-105R).

Medicaid: A Program Highly Vulnerable to Fraud (Testimony, 2/25/94, GAO/T-HEHS-94-106).

Homelessness: Appropriate Controls Implemented for 1990 McKinney Amendments' PATH Program (Report, 2/22/94, GAO/HEHS-94-82).

Safe Medical Devices (Letter, 2/10/94, GAO/HEHS-94-86R).

Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratio Standards, 1988-91 (Report, 2/7/94, GAO/HEHS-94-47).

FDA Safety Devices (Letter, 2/2/94, GAO/HEHS-94-90R).

Medicare: New Claims Processing System Benefits and Acquisition Risks (Report, 1/25/94, GAO/HEHS/AIMD-94-79).

Health and Safety: DOE's Implementation of a Comprehensive Health Surveillance Program Is Slow (Report, 12/16/93, GAO/RCED-94-47).

Hospitals: Chief Executives' Compensation (Testimony, 12/7/93, GAO/T-HRD-94-70).

Education

Selected Summaries

School-Age Children: Poverty and Diversity Challenge Schools Nationwide (Report, 4/29/94, GAO/HEHS-94-132). Testimony on same topic (3/16/94, GAO/T-HEHS-94-125).

The face of school-age America is changing dramatically. By 1990, one out of every six children lived in poverty and many were from diverse racial and ethnic backgrounds. Along with these changes, schools face additional problems—one-sixth of the nation's third-graders change schools frequently, attending at least three different schools since the beginning of first grade. Many school districts are also teaching a large number of immigrant students, often who are limited English proficient. This testimony discusses changes in the demographic characteristics of America's school-age children and the implications these changes have on America's schools and on education policy.

Special Education Reform: Districts Grapple With Inclusion Programs (Testimony, 4/28/94, GAO/T-HEHS-94-160).

In an inclusion program, all students, no matter what their disabilities, are taught in a general education classroom. If such programs become widespread, 3.2 million disabled students now assigned to segregated special education classrooms could be affected. GAO testified that inclusion programs can work, but they take tremendous efforts and considerable resources. Some of those GAO spoke with—parents, teachers, and administrators—generally supported these programs because of the positive effects observed for the disabled students, their nondisabled classmates, and school staff. But sufficient levels of effort and resources to implement inclusion programs may not be possible for many districts. Many educators and parents urged districts attempting inclusion programs to go slow.

Military Dependents' Education: Current Program Information and Potential Savings in DODDS (Testimony, 4/26/94, GAO/T-HEHS-94-155).

This testimony provides information on the current costs and enrollments for the following four military education programs: Department of Defense Dependents Schools (DODDS), Section 6 schools, the Impact Aid program, and the DOD program that provides supplemental financial aid to school

districts with large numbers of students who are military dependents. GAO testified that the military downsizing overseas has reduced DODDS enrollment considerably, Section 6 schools are relatively unaffected, and the number of military Impact Aid children has increased slightly. GAO also discussed savings that could be achieved in DODDS but which would require changing long-standing policies and practices.

Immigrant Education: Federal Funding Has Not Kept Pace With Student Increases (Testimony, 4/14/94, GAO/T-HEHS-94-146). Report on same topic (4/15/91, GAO/HRD-91-50).

More than 2 million immigrant students enrolled in the nation's schools during the past decade. The geographic concentration of these students has increased the financial burden of some school districts. GAO discussed the following key findings: (1) program funds are provided to school districts with large numbers of immigrant students; (2) program funding is not keeping pace with the increasing number of eligible students; and (3) many students eligible for program funds also participate in other federally funded education programs, but estimates are hard to obtain. The increased enrollment of immigrant students pose costly and increasing challenges for many districts, but there is little likelihood of substantially increased federal appropriations.

Elementary School Children: Many Change Schools Frequently, Harming Their Education (Report, 2/4/94, GAO/HEHS-94-45).

One in six of the nation's children who are third-graders—over a half million—have changed schools frequently, attending at least three different schools since the beginning of first grade. Unless policymakers focus greater attention on the needs of children who have changed schools frequently—often low-income, inner city, migrant, and limited English proficient (LEP)—these children may continue to be low achieving in math and reading. Local school districts generally provide little additional help to assist children who move frequently. The Department of Education can play a role in helping these children receive appropriate educational services in a timely manner. Specifically, the department could develop strategies to ensure that all children have access to Migrant Children and Chapter 1 services. School districts need access to a system that provides information on a more timely basis.

Limited English Proficiency: A Growing and Costly Educational Challenge Facing Many School Districts (Report, 1/28/94, GAO/HEHS-94-38).

The nation's ability to achieve the national education goals is increasingly dependent on its ability to educate LEP students. Many LEP students in the five districts that we visited received limited support in understanding academic subjects, such as math and social studies. Educators and researchers have developed approaches to provide academic subject instruction to LEP when native language instruction is not possible. The effectiveness of these programs, however, has not been definitely established. Federal programs targeted to LEP students provide important types of services for improving the education of these students; however, federal funding has not kept pace with the increase in the LEP population.

Student Loans: Millions Loaned Inappropriately to U.S. Nationals at Foreign Medical Schools (Report, 1/21/94, GAO/HEHS-94-28).

The U.S. Department of Education has not met its statutory responsibility to ensure the comparability of foreign medical schools to schools in the United States before authorizing their participation in the student loan program. As a result, GAO estimates that Education made $118 million in loans between 1986 and 1991 to students attending foreign medical schools without assuring that the schools met U.S. standards. State medical boards are often unable to get information they need to evaluate the education of foreign-trained physicians before licensing them. As a result, educationally underqualified physicians my be entering the mainstream of American medicine.

Higher Education: Information on Minority-Targeted Scholarships (Report, 1/14/94, GAO/HEHS-94-77).

Although many schools awarded minority-targeted scholarships, these scholarships accounted for a small proportion of total scholarships and scholarship dollars in the 1991-92 academic year. Most schools awarding minority-targeted scholarships used race or ethnicity as an eligibility requirement, while few used gender, religion, or other minority status. Race or ethnicity was rarely the sole criterion; most minority-targeted scholarships used additional criteria, such as financial need or academic merit, for awarding funds. Students receiving race-or ethnicity-based minority-targeted scholarships made up a small percentage of all racial or ethnic minority students. Four of the six schools we visited used minority-targeted scholarships to a great extent and found them valuable tools in recruiting and retaining minority students.

Rural Children: Increasing Poverty Rates Pose Educational Challenges (Report, 1/11/94, GAO/HEHS-94-75BR).

During the 1980s, the total number of rural children declined and the number of poor children in rural areas increased. In addition, other risk factors were prevalent among poor rural children, including a growth in the number of single-female-parent families and a continued high percentage of parents with low education levels. Rural poverty was concentrated by region and by race and ethnicity. Rural counties make up over 80 percent of the counties that, under the administration's proposed county eligibility changes in the Chapter 1 program, would no longer be eligible for basic or concentration grants.

School-Linked Human Services: A Comprehensive Strategy for Aiding Students at Risk of School Failure (Report, 12/30/93, GAO/HRD-94-21).

Many different models exist for coordinating human services in schools, and no two are exactly alike. Despite the variety of program models, we found that strong leadership was one of several common characteristics of the comprehensive school-linked programs we reviewed. Some programs increase the likelihood that at-risk students will stay in school; however, few impact evaluations of these programs are available. The federal government could play an important role in promoting effective comprehensive programs for school-age children by providing support and guidance for the development of impact and cost effectiveness evaluations of these programs.

Other Education Products

GAO Work Related to ESEA of 1965 (Letter, 4/26/94, GAO/HEHS-94-156R).

Hispanic Dropouts and Federal Programs (Letter, 4/6/94, GAO/PEMD-94-18R).

Default Rates at Historically Black Colleges and Universities (Letter, 3/9/94, GAO/HEHS-94-97R).

Peace Corps: Status of the Educational Assistance Grants Demonstration Program (Report, 2/25/94, GAO/NSIAD-94-89).

Total Quality Education (Letter, 2/10/94, GAO/HEHS-94-76R).

Deaf Education: Improved Oversight Needed for National Technical Institute for the Deaf (Report, 12/16/93, GAO/HRD-94-23).

Food Assistance: Schools That Left the National School Lunch Program (Report, 12/3/93, GAO/RCED-94-36BR).

Employment

Selected Summaries

Multiple Employment Training Programs: Major Overhaul Is Needed (Testimony, 3/3/94, GAO/T-HEHS-94-109).

By GAO's count, at least 154 programs administered by 14 federal departments and agencies provide about $25 million in employment training assistance. Too often the current fragmented system of programs (1) creates confusion and frustration for clients and administrators, (2) does not tailor services to the needs of those seeking assistance, and (3) creates the potential for duplication of effort and unnecessary administrative costs. In addition, some programs lack basic tracking and monitoring systems needed to ensure that assistance is provided efficiently and effectively. GAO is convinced that a major structural overhaul and consolidation of employment training programs is needed. The result would be to create a customer-driven employment system consisting of significantly fewer programs that embodies four guiding principles—simplicity, tailored services, administrative efficiency, and accountability.

Multiple Employment Training Programs: Most Federal Agencies Do Not Know If Their Programs Are Working Effectively (Report, 3/2/94, GAO/HEHS-94-88).

Federal agencies closely monitor their expenditure of billions of dollars for employment training assistance for the economically disadvantaged. However, most agencies do not collect information on participant outcomes nor do they conduct studies of program effectiveness. For about half the programs in GAO's analysis, agencies did not collect data on what happened to program participants after they completed a particular program (i.e., neither whether they obtained jobs nor what wages they earned). Only about a third of the training programs in GAO's analysis used oversight and monitoring to assess participant outcomes. The federal agencies responsible for these programs seldom conducted studies that measure program effectiveness or impact.

Occupational Safety and Health: Changes Needed in the Combined Federal-State Approach (Report, 2/28/94, GAO/HEHS-94-10). Testimony on same topic (10/20/93, GAO/T-HRD-94-3).

The Occupational Safety and Health Administration's (OSHA) oversight of state-operated safety and health programs continues to have substantial weaknesses like those identified 5 years ago by GAO and the Office of Inspector General (OIG). OSHA focuses primarily on measurers of program activities(for example, number of inspections conducted) rather than program outcome measures (such as reductions in workplace injuries). OSHA made some changes to its oversight process in the special evaluations conducted after a serious industrial accident in 1991, but few changes were incorporated since that time. OSHA and state programs pursue generally similar approaches to improving workplace safety and health. However, all state-administered programs differ from OSHA in that they cover state and local government employees, while OSHA does not.

EEOC's Expanding Workload: Increases in Age Discrimination and Other Charges Call for New Approach (Report, 2/9/94, GAO/HEHS-94-32).

The amount of time a person may wait to have the Equal Employment Opportunity Commission (EEOC) process a discrimination charge under the Age Discrimination in Employment Act of 1967 (ADEA) and other nondiscrimination laws could more than double and approach 21 months by fiscal year 1996. The current trend of a steadily increasing workload without commensurate increases in resources is expected to continue. Former and current EEOC officials and civil rights experts have suggested several options that they believe could improve the federal government's ability to enforce nondiscrimination laws in the workplace. The one mentioned most often is increased use of alternative dispute resolution approaches, such as mediation. GAO believes that the Congress should establish a commission of experts to consider this and other options for improvement. EEOC officials do not believe EEOC will initiate substantially more systemic charges or litigate significantly more charges under ADEA and other nondiscrimination laws because resources are limited.

Multiple Employment Training Programs: Overlapping Programs Can Add Unnecessary Administrative Costs (Report, 1/28/94, GAO/HEHS-94-80).

Many federal employment training programs target the same populations. The overlap in client groups targeted by federal programs ranged from a low of 4 programs each, serving refugees and older workers, to a high of 18 programs, serving veterans. This overlap can add unnecessary

administrative costs at each level of government—federal, state, and local. Individually, each employment training program generally has a well-intended purpose. However, collectively these programs create the potential for duplication of effort, raising questions concerning the administrative costs associated with the multitude of federal, state, and local agencies involved in operating these programs.

Multiple Employment Training Programs: Conflicting Requirements Hamper Delivery of Services (Report, 1/28/94, GAO/HEHS-94-78).

Conflicting eligibility requirements and differences in annual operating cycles are hampering the ability of programs to provide participants needed services. Despite decades of efforts to better coordinate employment training programs, conflicting requirements continue to make it difficult for program staff to coordinate activities and share resources. Differences in eligibility criteria make determining who is eligible for which program a complex process that confuses clients and frustrates administrators. Within each target group, differences in annual operating cycles also hamper the ability of program administrators to plan together to ensure participants receive the services they need.

Occupational Safety and Health: Differences Between Programs in the United States and Canada (Report, 12/6/93, GAO/HRD-94-15FS).

Programs to ensure occupational safety and health in the United States compared with those in Canada differ in three major areas: (1) the governmental entity responsible for operating and funding the programs, (2) the extent of worker involvement, and (3) the type of enforcement action taken. Several state-operated programs in the United States use program elements similar to those used in Canada. These states provide some information on how these programs might work in the United States. Little information is available on the effectiveness of the programs in Canada, although employer and worker representatives with whom we spoke expressed general satisfaction.

Other Employment Products

Employment Discrimination: How Registered Representatives Face Discrimination (Report, 3/30/94, GAO/HEHS-94-17).

Federal Employment: Impact of the President's Budget on Federal Employees (Testimony, 03/10/94, GAO/T-GGD-94-108).

Multiple Employment Training Programs: Conflicting Requirements Underscore Need for Change (Testimony, 3/10/94, GAO/T-HEHS-94-120).

Sex Discrimination: Agencies' Handling of Sexual Harassment and Related Complaints (Testimony, 3/8/94, GAO/T-OSI-94-22).

Sex Discrimination: DEA's Handling of Sexual Harassment and Other Complaints (Report, 3/4/94, GAO/OSI-94-10).

Job Training Partnership Act: Labor Title IV Could Improve Relations With Native Americans (Report, 3/4/94, GAO/HEHS-94-67).

EEO at the National Park Service (Letter, 3/3/94, GAO/GGD-94-54R).

Department of Labor: Noncompetitive, Discretionary Grants (Report, 2/22/94, GAO/HEHS-94-9).

Federal Personnel: The EEO Implications of Reductions-In-Force (Testimony, 2/1/94, GAO/T-GGD-94-87).

Military Downsizing: Persons Returning to Civilian Life Need More Help From DOD (Report, 1/21/94, GAO/HEHS-94-39).

Dislocated Workers: A Look Back at the Redwood Employment Training Programs (Report, 12/13/93, GAO/HRD-94-16BR).

Social Security & Welfare

Selected Summaries

Underfunded Pension Plans: Federal Government's Growing Exposure Indicates Need for Stronger Funding Rules (Testimony, 4/19/94, GAO/T-HEHS-94-149).

The Pension Protection Act of 1987 added a new funding requirement for sponsors of underfunded defined benefit pension plans—section 412(1) of the Internal Revenue Code. Evidence shows that pension plan funding is not improving. GAO studied a randomly selected sample of plans and found that (1) only about 40 percent of the sponsors of plans subject to section 412(1) were making additional contributions in 1990 and (2) the amount of

additional contributions was less than 3 percent of the plans' underfunding. The amount sponsors were allowed to use to reduce their additional contributions (the offset) was much greater than the unreduced additional contributions for some plans. GAO believes that the provisions in H.R. 3396 could and should be strengthened to ensure that sponsors of a greater percentage of underfunded plans make additional contributions.

Infants and Toddlers: Dramatic Increases in Numbers Living in Poverty (Report, 4/7/94, GAO/HEHS-94-74).

During the 1980s, the number of poor infants and toddlers increased by 26 percent—from about 1.8 million in 1980 to about 2.3 million in 1990. Further, in some cities and rural areas, over 45 percent of all infants and toddlers lived in poverty in 1990. Poor and near-poor infants and toddlers were also more likely than nonpoor children to be immigrants and live in (1) families where no person over the age of 14 spoke English well, (2) families with one parent, (3) families where parents had low educational attainment, or (4) families where the parents did not work. Infants and toddlers were also more likely to be in these risk groups in 1990 than they were in 1980. GAO also found that federal early childhood programs generally provide services to only a small percentage of poor and near-poor infants and toddlers.

Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children (Report, 4/4/94, GAO/HEHS-94-89).

GAO reviewed foster care programs in California, New York, and Pennsylvania, the states with the largest average foster care populations in 1991. The 1991 population of young foster children is significantly different from the 1986 population in the locations reviewed in a variety of ways. The 1991 population size is much larger, more of these children entered foster care due to some form of neglect, their biological parents are more likely to abuse drugs, these children have more health-related problems and are at high risk for further problems due to prenatal drug exposure, and they are more likely to be eligible for federal maintenance payments.

Social Security: Continuing Disability Review Process Improved, but More Targeted Reviews Needed (Testimony, 3/10/94, GAO/T-HEHS-94-121). Report on same topic (7/8/93, GAO/HRD-93-109).

GAO is encouraged by the Social Security Administration's (SSA) efforts to make the continuing disability review process more efficient and

cost-effective through the use of computer profiling and beneficiary self-reported data. GAO is concerned, however, that SSA continues to do too few continuing disability reviews, particularly for beneficiaries with the greatest likelihood of being removed from the disability rolls. In GAO's view, finding ways to provide SSA with more money to do the reviews is worthwhile.

Social Security: Disability Benefits for Drug Addicts and Alcoholics Are Out of Control (Testimony, 2/10/94, GAO/T-HEHS-94-101).

The number of addicts receiving disability benefits has grown substantially during the last 5 years. Currently, about 250,000 addicts receive disability benefits at an annual cost of about $1.4 billion under the Social Security Administration's Disability Insurance (DI) and Supplemental Security Income (SSI) programs. Under SSI, certain addicts are required to participate in treatment for their addiction and have a representative payee manage their benefits. As of August 31, 1993, about 70,000 were covered by that requirement, which provides benefits to addicts who would not qualify for disability if their addiction ended. The DI program has no similar requirement. Virtually all of the addicts in the SSI drug addiction and alcoholism (DA&A) program have representative payees. However, for the rest of the addict population receiving benefits, less than half have payees. GAO believes that all addicts should have payees. In those situations where payees are present, it is questionable how tightly these payees control the use of benefits. GAO makes a number of recommendations to strengthen controls over benefit payments to addicts.

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (Report, 2/8/94, GAO/HEHS-94-34).

In 1993, the SSA actuary forecasted that DI rolls would continue growing and would nearly double to over six million disabled workers in the next 10 years. Insured persons are applying for benefits at a higher rate, higher percentages of applicants are accepted for benefits, and the rate at which beneficiaries leave the program has been declining. Changes in the characteristics of new beneficiaries have accompanied this growth. Several reasons for the growth and change in the DI rolls have been identified. However, quantitative data on the impact of these reasons are lacking, and important questions remain. Without better information, neither SSA nor the Congress can be sure whether the current growth will continue or whether the trends might reverse as they have done in the past.

Residential Care: Some High-Risk Youth Benefit, but More Study Needed (Report, 1/28/94, GAO/HEHS-94-56).

Residential care appears to be a viable treatment option for some high-risk youths. Each of the 18 programs we contacted reported benefits for some youths in such areas as maintaining attendance in school and avoiding drug abuse and criminal behavior. However, the programs seldom conducted controlled or comparison studies to determine how outcomes are linked to their treatment efforts, and few programs have conducted studies to show what happened to participants more than 12 months after they left the programs.

Older Americans Act: Title III Funds Not Distributed According to Statute (Report, 1/18/94, GAO/HEHS-94-37).

The method followed by the Administration on Aging (AoA) in allotting funds under title III of the Older Americans Act is inconsistent with the act's basic requirement that the distribution of funds among the states be proportional to their elderly populations to the maximum extent possible. Under AoA's method, the amounts allotted per elderly person are not equal in similarly populated states, and states with more rapidly growing elderly populations are underfunded.

Other Social Security & Welfare Products

Quality Assurance Independence (Letter, 4/28/94, GAO/HEHS-94-151R).

Local Tax Abatement (Letter, 4/21/94, GAO/HEHS-94-84R).

Social Security Administration: Major Changes in SSA's Business Processes Are Imperative (Testimony, 4/14/94, GAO/T-AIMD-94-106).

Federal Mandates: Unfunded Requirements Concern State and Local Officials (Letter, 4/5/94, GAO/HEHS-94-110R).

Vietnamese Amerasian Resettlement: Education, Employment, and Family Outcomes in the United States (Report, 3/31/94, GAO/PEMD-94-15).

Social Security Administration: Many Letters Difficult to Understand (Testimony, 3/22/94, GAO/T-HEHS-94-126).

Automated Welfare Systems: Historical Costs and Projections (Report, 02/25/94, GAO/AIMD-94-52FS).

Older Americans Act: The National Eldercare Campaign (Report, 2/23/94, GAO/PEMD-94-7).

Child Care Quality: States' Difficulties Enforcing Standards Confront Welfare Reform Plans (Testimony, 2/11/94, GAO/T-HEHS-94-99).

Davis-Bacon Act (Letter, 2/7/94, GAO/HEHS-94-95R).

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1993 (Report, 12/22/93, GAO/HRD-94-73).

Breastfeeding: WIC's Efforts to Promote Breastfeeding Have Increased (Report, 12/16/93, GAO/HRD-94-13).

Grant Administration: CDC Oversight of Grantees' Activities Needs Improvement (Report, 12/10/93, GAO/HRD-94-12).

Refugee Resettlement: Unused Federal Funds in 1991 and 1992 (Report, 12/7/93, GAO/HRD-94-44).

Veterans Affairs and Military Health

Selected Summaries

Veterans' Health Care: Most Care Provided Through Non-VA Programs (Report, 4/25/94, GAO/HEHS-94-104BR).

Nine out of 10 veterans have non-VA health care coverage. Veterans with Medicare coverage are unlikely to use VA services. Seven out of 10 federal dollars spent on veterans' health care come from non-VA programs. Expenditures on veterans' health care through private health insurance likely exceed those under VA health care. Veterans using VA services tend to have lower incomes and less private health insurance coverage than nonusers. Health reform could reduce VA's role as a safety net for acute-care services. President Clinton's proposed Health Security Act is the only major health reform proposal that would change the role of the VA health care system. The report points out several other options exist for restructuring the VA health care system.

Veterans' Health Care: Veterans' Perceptions of VA Services and Its Role in Health Care Reform (Testimony, 4/20/94, GAO/T-HEHS-94-150).

GAO presented the views obtained from discussions with small groups of veterans on the current veterans health care system and the future role of the Department of Veterans Affairs (VA). Several themes emerged: (1) veterans, other than those without health insurance, seemed to use VA only for certain services, such as treatment of service connected disabilities; (2) veterans' satisfaction with VA health care varied by location, but focused mainly on poor customer service; (3) veterans perceive that the care offered by VA can be erratic and some questioned the quality of care offered by facilities at other locations; (4) veterans expressed concern that changes could diminish or eliminate veterans' health benefits; (5) some veterans did not see a need to maintain separate veterans' health care facilities, as long as veterans were given a viable alternative; and (6) veterans frequently indicated the needs of veterans with service-connected disabilities should receive the highest priority.

Defense Health Care: Challenges Facing DOD in Implementing Nationwide Managed Care (Testimony, 4/19/94, GAO/T-HEHS-94-145).

DOD has made substantial progress in implementing its nationwide managed health care program called TRICARE. GAO commends DOD officials for tackling this ambitious but necessary undertaking. TRICARE embodies many of the lessons learned from DOD's managed health care demonstration projects over the last several years. GAO believes TRICARE offers the potential for improving beneficiary access to care, maintaining high-quality care, and gaining control of health care needs. Analyses conducted to date, however, show that it is uncertain whether TRICARE will be more cost effective than other health care options available to DOD. Given the complexity of TRICARE, several unaddressed implementation and contracting issues remain.

VA Health Care For Women: In Need of Continued VA Attention (Testimony, 3/9/94, GAO/T-HEHS-94-114). Testimony on same topic (7/2/92, GAO/T-HRD-92-33, and 7/19/92, GAO/T-HRD-92-42). Reports on same topic (9/24/82, GAO/HRD-82-98, and 1/23/92, GAO/HRD-92-23).

GAO conducted a limited follow-up to its January 1992 report on improvements needed in the Department of Veterans Affairs' (VA) provision of health care services to women veterans. Since 1992, VA's central office has repeatedly stressed the need for its facilities to improve services for women veterans and has issued guidance to its medical

centers intended to address the problems identified in our report. Although its central office has not effectively monitored field facilities to ensure that they improved service for women veterans, VA has had great success in improving privacy for women veterans.

Homelessness: Demand for Services to Homeless Veterans Exceeds VA Program Capacity (Report, 2/23/94, GAO/HEHS-94-98).

Despite the good-faith efforts of VA program staff, the capacity at VA's programs to serve homeless veterans is far short of the demand for such services. Further, VA services for homeless veterans are not available in many localities in the United States. Prior to release of a patient from a VA medical center, Homeless Chronically Mentally Ill or Domiciliary Care for Homeless Veterans program, VA staff are expected to refer the veteran to other VA or community providers when further care is needed, and follow up with veterans after discharge to monitor their post-treatment status. VA staff seldom monitored the veterans' progress after release from VA inpatient facilities. In addition, VA has made little progress in compiling a comprehensive inventory of the needs of the homeless veteran population as required by Public Law 102-405.

VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (Report, 12/10/93, GAO/HRD-94-27).

High-risk patients leaving a treatment setting without staff authorization is a significant problem at 39 of VA's 158 medical centers. Systemwide, about 7,000 searches were conducted for high-risk patients who were reported as missing from their treatment settings during the two-year period of October 1, 1990, through September 30, 1992. While 99 percent of these patients were ultimately found unharmed, VA officials discovered that 34 others were dead and 19 were injured. Further, 25 remained unaccounted for as of June 1, 1993.

Other Veterans and Military Health Products

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (Report, 3/29/94, GAO/HEHS-94-113FS).

Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards (Report, 3/23/94, GAO/NSIAD-94-36).

VA Appropriations (Letter, 3/29/94, GAO/HRD-94-127R).

Homelessness: Demand for Services to Homeless Veterans Exceeds VA Program Capacity (Report, 2/23/94, GAO/HEHS-94-98).

Defense Health Care: Expansion of CHAMPUS Reform Initiative Into DOD's Region 6 (Report, 2/9/94, GAO/HEHS-94-100).

Military Downsizing: Persons Returning to Civilian Life Need More Help From DOD (Report, 1/21/94, GAO/HEHS-94-39).

VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (Report, 12/10/93, GAO/HRD-94-27).

VA Appropriations (Letter, 12/10/93, GAO/HRD-94-72R).

Veterans Benefits: Redirected Modernization Shows Promise (Report, 12/9/93, GAO/AIMD-94-26).

Health (Comprehensive 2-Year Listing)

Access and Infrastructure

Health Care Access: Innovative Programs Using Nonphysicians (Report, 8/27/93, GAO/HRD-93-128).

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, 7/22/93, GAO/HRD-93-124).

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, 4/22/93, GAO/HRD-93-56). Testimony on same topic (4/22/93, GAO/T-HRD-93-17).

Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention (Report, 4/9/93, GAO/HRD-93-48).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, 1/29/93, GAO/HRD-93-44).

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, 1/4/93, GAO/HRD-93-4).

District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (Report, 12/29/92, GAO/HRD-93-28).

Bone Marrow Transplants: National Program Has Greatly Increased Pool of Potential Donors (Report, 11/4/92, GAO/HRD-93-11).

Access to Health Care: States Respond to Growing Crisis (Report, 6/16/92, GAO/HRD-92-70). Testimony on same topic (6/9/92, GAO/T-HRD-92-40).

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (Report, 5/28/92, GAO/HRD-92-73FS).

Access to Health Insurance: States Efforts to Assist Small Businesses (Report, 5/14/92, GAO/HRD-92-90). Testimony on same topic (5/14/92, GAO/T-HRD-92-30).

Employee and Retiree Health Benefits

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (Report, 7/9/93, GAO/HRD-93-125).

Family and Medical Leave Cost Estimate (Letter, 2/1/93, GAO/HRD-93-14R).

Employee Benefits: Financing Health Benefits of Coal Industry Retirees (Report, 7/22/92, GAO/HRD-92-137FS).

Employee Benefits: Financing Health Benefits of Retired Coal Miners (Report, 7/22/92, GAO/HRD-92-130FS).

Federal Health Benefits Program: Open Season Processing Timeliness (Report, 7/8/92, GAO/GGD-92-122BR).

Information on Federal Health Benefits Costs (Letter, 6/23/92, GAO/GGD-92-18R).

Federal Health Benefits Program (Letter, 5/4/92, GAO/GGD-92-11R).

Financing

Health Care: Antitrust Enforcement Under Maryland Hospital All-Payer System (Report, 4/27/94, GAO/HEHS-94-81).

Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (Report, 4/13/94, GAO/HEHS-94-71).

Medigap Loss Ratios, First 2 Years (Letter, 4/4/94, GAO/HEHS-94-131R).

Medical Review Saving (Letter, 2/28/94, GAO/HEHS-94-93R).

Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratio Standards, 1988-91 (Report, 2/7/94, GAO/HEHS-94-47).

Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (Report, 12/27/93, GAO/HRD-94-26). Testimony on same topic (11/5/93, GAO/T-HRD-94-55).

Hospitals: Chief Executives' Compensation (Testimony, 12/7/93, GAO/T-HRD-94-70).

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (Report, 11/22/93, GAO/HRD-94-40).

1993 German Health Reforms: Initiatives Tighten Cost Controls (Testimony, 10/13/93, GAO/T-HRD-94-2). Report on same topic (7/7/93, GAO/HRD-93-103).

1993 German Health Reforms: New Cost Control Initiatives (Report, 7/7/93, GAO/HRD-93-103). Testimony on same topic (10/13/93, GAO/T-HRD-94-2).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, 3/8/93, GAO/T-HRD-93-8).

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, 2/4/93, GAO/T-HRD-93-3). Report on same topic (5/7/92, GAO/HRD-92-69). Testimony on same topic (5/7/92, GAO/T-HRD-92-29).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, 1/29/93, GAO/HRD-93-44).

Removal of Breast Implants (Letter, 12/7/92, GAO/HRD-93-5R).

Trauma Care Reimbursement: Poor Understanding of Losses and Coverage for Undocumented Aliens (Report, 10/15/92, GAO/PEMD-93-1).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, 9/22/92, GAO/HRD-92-125).

Hospital Costs: Adoption of Technologies Drives Cost Growth (Report, 9/9/92, GAO/HRD-92-120).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (Testimony, 7/28/92, GAO/T-HRD-92-49).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, 5/7/92, GAO/HRD-92-69). Testimony on same topic (5/7/92, GAO/T-HRD-92-29).

Health Care Reform Related Issues

Health Care Alliances: Issues Relating to Geographic Boundaries (Report, 4/8/94, GAO/HEHS-94-139). Testimony on same topic (2/24/94, GAO/T-HEHS-94-108).

Health Care Reform: How Proposals Address Fraud and Abuse (Testimony, 3/17/94, GAO/T-HEHS-94-124).

Health Care in Hawaii: Implications for National Reform (Testimony, 3/16/94, GAO/T-HEHS-94-123). Report on same topic (2/11/94, GAO/HEHS-94-68).

Health Care Reform: Supplemental and Long-Term Care Insurance (Testimony, 11/9/93, GAO/T-HRD-94-58).

Health Insurance: How Health Care Reform May Affect State Regulation (Testimony, 11/5/93, GAO/T-HRD-94-55).

Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (Testimony, 3/31/93, GAO/T-HRD-93-12).

Health Care: Problems and Potential Lessons for Reform (Testimony, 3/27/92, GAO/T-HRD-92-23).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (Testimony, 3/3/93, GAO/T-HRD-93-7).

Transition Series: Health Care Reform (Report, 12/92, GAO/OCG-93-STR).

State Health Care Reform: Federal Requirements Influence State Reforms (Testimony, 9/9/92, GAO/T-HRD-92-55). Report on same topic (6/16/92, GAO/HRD-92-70). Testimony on same topic (6/9/92, GAO/T-HRD-92-40).

HHS Public Health Service Agencies

Safe Medical Devices (Letter, 2/10/94, GAO/HEHS-94-86R).

FDA Safety Devices (Letter, 2/2/94, GAO/HEHS-94-90R).

CDC Activities Are Appropriate and Non-Duplicative (Letter, 8/30/93, GAO/HRD-93-32R).

FDA Regulation of Dietary Supplements (Letter, 7/2/93, GAO/HRD-93-28R).

Hospital Sterilants: Insufficient FDA Regulation May Pose a Public Health Risk (Report, 6/14/93, GAO/HRD-93-79).

Alleged Lobbying Activities: Office for Substance Abuse Prevention (Report, 5/4/93, GAO/HRD-93-100).

FDA Premarket Approval: Process of Approving Iodine as a Drug (Report, 4/12/93, GAO/HRD-93-81).

Public Health Service: Evaluation Set-Aside Has Not Realized Its Potential to Inform the Congress (Report, 4/8/93, GAO/PEMD-93-13).

Women's Health: FDA Needs to Ensure More Study of Gender Differences in Prescription Drug Testing (Report, 10/29/92, GAO/HRD-93-17).

Food Safety and Quality: FDA Strategy Needed to Address Animal Drug Residues in Milk (Report, 8/5/92, GAO/RCED-92-209).

Long-Term Care

Long-Term Care Reform: Program Eligibility, States' Service Capacity, and Federal Role in Reform Need More Consideration (Testimony, 4/14/94, GAO/T-HEHS-94-144).

Long-Term Care: The Need for Geriatric Assessment in Publicly Funded Home and Community-Based Programs (Testimony, 04/14/94, GAO/T-PEMD-94-20).

Long-Term Care: Demography, Dollars, and Dissatisfaction Drive Reform (Testimony, 4/12/94, GAO/T-HEHS-94-140).

Long-Term Care: Status of Quality Assurance and Measurement in Home and Community Based Services (Report, 3/31/94, GAO/PEMD-94-19).

Long-Term Care: Support for Elder Care Could Benefit the Government Workplace and the Elderly (Report, 3/4/94, GAO/HEHS-94-64).

Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (Report, 1/31/94, GAO/HEHS-94-60).

Health Care Reform: Supplemental and Long-Term Care Insurance (Testimony, 11/9/93, GAO/T-HRD-94-58).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (Report, 8/25/93, GAO/HRD-93-129).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, 7/27/93, GAO/HRD-93-68).

Long-Term Care Forum (Discussion Paper, 7/13-14/93, GAO/HRD-93-1-SP).

Long-Term Care Insurance: Tax Preferences Reduce Costs More for Those in Higher Tax Brackets (Report, 6/22/93, GAO/GGD-93-110).

Massachusetts Long-Term Care (Letter, 5/17/93, GAO/HRD-93-22R).

Long-Term Care Case Management: State Experiences and Implications for Federal Policy (Report, 4/6/93, GAO/HRD-93-52).

Long-Term Care Insurance Partnerships (Letter, 9/25/92, GAO/HRD-92-44R).

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (Testimony, 6/23/92, GAO/T-HRD-92-44). Reports on same topic (3/27/92, GAO/HRD-92-66 and 12/26/91, GAO/HRD-92-14). Testimonies on same topic (5/20/92, GAO/T-HRD-92-31 and 4/11/91, GAO/T-HRD-91-14).

Malpractice

Medical Malpractice Insurance Options (Letter, 2/28/94, GAO/HEHS-94-105R).

Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs (Report, 10/25/93, GAO/HRD-94-8).

Medical Malpractice: Estimated Savings and Costs of Federal Insurance at Health Centers (Report, 9/24/93, GAO/HRD-93-130).

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, 8/11/93, GAO/HRD-93-126).

Medical Malpractice: Experience With Efforts to Address Problems (Testimony, 5/20/93, GAO/T-HRD-93-24).

Health Information Systems: National Practitioner Data Bank Continues to Experience Problems (Report, 1/29/93, GAO/IMTEC-93-1).

Practitioner Data Bank: Information on Small Medical Malpractice Payments (Report, 7/7/92, GAO/IMTEC-92-56).

Managed Care

Managed Health Care: Effect on Employers' Costs Difficult to Measure (Testimony, 2/2/94, GAO/T-HEHS-94-91). Report on same topic (10/19/93, GAO/HRD-94-3).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (Report, 10/19/93, GAO/HRD-94-3).

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (Report, 9/7/93, GAO/HRD-93-121).

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiative (Testimony, 5/10/93, GAO/T-HRD-93-21).

Medicaid: HealthPASS—An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, 5/7/93, GAO/HRD-93-67).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (Report, 3/17/93, GAO/HRD-93-46). Testimony on same topic (3/17/93, GAO/T-HRD-93-10).

Medicaid: Factors to Consider in Managed Care Programs (Testimony, 6/29/92, GAO/T-HRD-92-43).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (Report, 6/19/92, GAO/HRD-92-89).

Medicare and Medicaid

Medicare: Impact of OBRA 90's Dialysis Provisions (Report, 4/25/94, GAO/HEHS-94-65).

Medicare Transaction System (Letter, 4/20/94, GAO/HEHS-94-143R).

Medicare: Beneficiary Liability for Certain Paramedic Services May Be Substantial (Report, 4/15/94, GAO/HEHS-94-122BR).

Medicare Diagnostic Imaging Rates (Letter, 4/5/94, GAO/HEHS-94-129R).

Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers (Testimony, 3/29/94, GAO/T-PEMD-94-17).

Los Angeles County Medi-Cal (Letter, 3/18/94, GAO/HEHS-94-116R).

Medicare: Greater Investment in Claims Review Would Save Millions (Report, 3/2/94, GAO/HEHS-94-35).

Medicaid: A Program Highly Vulnerable to Fraud (Testimony, 2/25/94, GAO/T-HEHS-94-106).

Medicare: New Claims Processing System Benefits and Acquisition Risks (Report, 1/25/94, GAO/HEHS/AIMD-94-79).

Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (Report, 1/20/94, GAO/HEHS-94-52).

Medicare/Medicaid Data Bank Issues (Letter, 11/15/93, GAO/HRD-94-63R).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (Testimony, 11/12/93, GAO/T-HRD-94-59).

Medicare: Better Guidance Is Needed To Preclude Inappropriate General and Administrative Charges (Report, 10/15/93, GAO/NSIAD-94-13).

HCFA Payment Rate for Erythropoietin (Letter, 10/13/93, GAO/HRD-94-1R).

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, 9/17/93, GAO/HRD-93-92).

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (Report, 9/7/93, GAO/HRD-93-121).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, 8/20/93, GAO/HRD-93-112FS).

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, 8/11/93, GAO/HRD-93-126).

Medicare Part B: Reliability of Claims Processing Across Four Carriers (Report, 8/11/93, GAO/PEMD-93-27).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (Report, 8/2/93, GAO/HRD-93-118). Testimony on same topic (8/2/93, GAO/T-HRD-93-28).

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, 7/21/93, GAO/HRD-93-98).

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