United States General Accounting Office

GAO

Health, Education, and Human Services Division Reports

August 1995

# Health
# Education
# Employment
# Social Security
# Welfare
# Veterans

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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, disability, 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 month and provides summaries for selected key products.
- Comprehensive 1-Year Listings: This section lists all products published in the last year, 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 appear at the end of this booklet. Instructions for getting on GAO's mailing list appear on page 43 of this booklet.

You may access the Most Recent GAO Products section of this booklet on Internet. Instructions appear on the last page of this booklet.

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Assistant Comptroller General

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## Abbreviations

| | |
|---|---|
| AFDC | Aid to Families With Dependent Children |
| AHCPR | Agency for Health Care Policy and Research |
| CARE | Comprehensive AIDS Resources Emergency Act |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CSRS | Civil Service Retirement System |
| DC | District of Columbia |
| DOD | Department of Defense |
| DOE | Department of Energy |
| EEO | Equal Employment Opportunity |
| EEOC | Equal Employment Opportunity Commission |
| ERISA | Employee Retirement Income Security Act of 1974 |
| GAO | General Accounting Office |
| HCFA | Health Care Financing Administration |
| HEHS | Health, Education, and Human Services Division, GAO |
| HHS | Department of Health and Human Services |
| HIV | human immunodeficiency virus |
| HMO | health maintenance organization |
| HRD | Human Resources Division, GAO |
| JOBS | Job Opportunities and Basic Skills program |
| NAFTA | North American Free Trade Agreement |
| NASA | National Aeronautics and Space Administration |
| NIH | National Institutes of Health |
| NPR | National Performance Review |
| NRC | Nuclear Regulatory Commission |
| OHA | Social Security Administration's Office of Hearings and Appeals |
| PBGC | Pension Benefit Guarantee Corporation |
| SBA | Small Business Administration |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| T&A | time and attendance |
| VA | Department of Veterans Affairs |
| WAIS | Wide Area Information Server |
| WWW | World Wide Web |

# Most Recent GAO Products (July 1995)

## Health

### Selected Summaries

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (Testimony, 7/31/95, GAO/T-HEHS-95-227).

GAO's work has shown that Medicare's vulnerability stems from a combination of factors: (1) higher than market rates for certain services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers alleviate these problems, but these techniques are not generally used in Medicare. The program's pricing methods and controls over utilization, consistent with health care financing and delivery 30 years ago, are not well aligned with today's major financing and delivery changes. To some extent, the predicament inherent in public programs—the uncertain line between adequate managerial control and excessive government intervention—helps explain the dissimilarity in the ways Medicare and private health insurers administer their respective plans.

Medicaid: Matching Formula's Performance and Potential Modifications (Testimony, 7/27/95, GAO/T-HEHS-95-226).

In 1965 when the Medicaid program was established, the matching formula was adopted to narrow the differences likely to result among the Medicaid programs of wealthier and poorer states. By giving poorer states (as measured by per capita income) a higher federal match, the formula was designed to reduce disparities across states in (1) population groups and services covered in each state program and (2) the tax burden imposed by the financing of Medicaid relative to the size of the state's financial resources. GAO has found that the Medicaid matching formula, with its reliance on per capita income as a measure of state wealth, has not significantly reduced wide differences in states' Medicaid programs or the tax burdens to support them. Large disparities persist in coverage of population groups and types of services as well as in the burdens state taxpayers bear in financing state programs. Certain modifications to the formula could enhance the ability of federal payments to narrow program disparities.

Medicare: Enhancing Health Care Quality Assurance (Testimony, 7/27/95, GAO/T-HEHS-95-224).

The Health Care Financing Administration (HCFA) has three quality assurance programs. These programs (1) assess whether fee-for-service institutional providers meet certain Medicare conditions of participation, (2) assess whether health maintenance organizations (HMO) meet similar requirements, and (3) review inpatient care and ambulatory surgery furnished under fee-for-service arrangements or by HMO providers. Although these programs represent reasonable approaches, GAO has reported serious problems with their implementation. HCFA is beginning to enhance its quality assurance programs in several ways. These changes include a greater emphasis on continuous quality management, performance measurement, and patient satisfaction. Furthermore, HCFA is strengthening its collaboration with the private sector. The changes HCFA is making will take advantage of successful private-sector approaches and are consistent with the recommendations of experts GAO interviewed. But HCFA faces a challenge in implementing these changes while avoiding the kind of implementation problems that have occurred with its past efforts.

Practice Guidelines: Overview of Agency for Health Care Policy and Research Efforts (Testimony, 7/25/95, GAO/T-HEHS-95-221).

In 1989 the Congress created the Agency for Health Care Policy and Research (AHCPR) within the Department of Health and Human Services (HHS) Public Health Service as the federal government's focal point for effectiveness and outcomes research. As part of this effort, the Congress directed the agency to sponsor the development of clinical practice guidelines. GAO found that during AHCPR's first 5 years, its performance has received mixed reviews from potential users of clinical guidelines. On the one hand, the agency has demonstrated strengths in the difficult process of guidelines development. It has been praised for its use of a rigorous, evidence-based methodology, multidisciplinary panels, and emphasis on health care consumers. On the other hand, however, weaknesses in the guidelines make them not very user friendly. Specifically, the agency has been criticized for the broadness of the guideline topics selected and the formats in which they are published. The agency is aware of these criticisms and plans to modify its guidelines-development efforts to improve the timeliness and presentation of its clinical practice guidelines.

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (Report, 7/25/95, GAO/HEHS-95-167). Testimony on same topic (7/25/95, GAO/T-HEHS-95-223).

Although the Employee Retirement Income Security Act of 1974 (ERISA) preemption effectively blocks states from regulating most employer-based health plans, it permits states to regulate health insurers. GAO estimates that roughly 114 million individuals (44 percent of the U.S. population) are covered by ERISA health plans. In most of these ERISA plans, the employer purchases health care coverage from a third-party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40 percent of these plans, covering about 44 million people, the employer chooses to self-fund and retain the risk for its health plan. Because these self-funded plans are not deemed to be insurance, ERISA preempts them from state regulation and premium taxation. All ERISA health plans, including self-funded ones, are subject to federal fiduciary and reporting standards. Available data suggest that self-funding is increasing, particularly among smaller firms. The growth of self-funding poses concerns for the states because fewer individuals are insured by health plans that states oversee.

Prescription Drugs and the Elderly: Many Still Receive Potentially Harmful Drugs Despite Recent Improvements (Report, 7/24/95, GAO/HEHS-95-152).

The inappropriate use of prescription drugs is a potential health problem that is particularly acute for the elderly. GAO's analysis of 1992 data from the Medicare Current Beneficiary Survey found that about 17.5 percent of almost 30 million noninstitutionalized Medicare recipients 65 or older used at least one drug identified as generally unsuitable for elderly patients since safer alternative drugs exist. Inappropriate prescription drug use can result from the behavior not only of the physician but also of the pharmacist and patient. Although the experts GAO interviewed agreed that the inappropriate use of prescription drugs remains a significant health problem, they identified several recent efforts that are helping to address this problem. Changes in the health care delivery system also have the potential to reduce the inappropriate use of prescription drugs.

Medicare: Adapting Private-Sector Techniques Could Curb Losses to Fraud and Abuse (Testimony, 7/19/95, GAO/T-HEHS-95-211).

Medicare could save billions of dollars by curbing fraud, waste, and abuse. These losses occur largely because of inappropriate pricing and

inadequate scrutiny of claims for payment and because abusive or poorly qualified providers of medical services and supplies are allowed to participate in the program. These problems are not unique to Medicare—they can be found elsewhere in both the public and private sectors. However, private payers have been able in many instances to react quickly through a variety of management approaches, whereas Medicare's pricing methods and controls over utilization, which were consistent with health care financing and delivery when the program started, have not been adapted to today's environment. Private-sector payers use modern management techniques, such as competitive bidding, advanced software programs, and preferred provider networks. If Medicare were able to apply appropriate private-sector techniques, its weaknesses could be significantly remedied.

Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (Report, 7/19/95, GAO/HEHS-95-175).

Policy changes to expand Medicaid eligibility for children helped to increase the number of children enrolled in Medicaid by 4.8 million between 1989 and 1993. However, the overall number of children who are uninsured did not decline because employment-based coverage for adults and children also declined during the same period. Because of expanded Medicaid coverage, children were not as affected by the loss of employment-based insurance as adults. Without expanded Medicaid coverage, many more children would have been uninsured in 1993. While the Medicaid expansion allowed many children to be covered who might otherwise be uninsured, a substantial number of uninsured children in 1993 were eligible but not enrolled in the program. At least one-quarter of currently uninsured children—2.3 million—met federal Medicaid age and income eligibility standards. Reasons that eligible children are not covered may include their parents' lack of knowledge about their potential eligibility and difficulties in applying for Medicaid.

Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (Testimony, 7/18/95, GAO/T-HEHS-95-205).

GAO found that federal and state laws reflect steps taken to improve the portability of health insurance, but the possibility remains that an individual's coverage would be reduced when changing jobs. Most private health plans still require waiting periods before making people with preexisting conditions fully eligible for coverage. On the basis of existing data on the number of people who change jobs and studies on the effect of

health insurance on job mobility, GAO estimates that roughly up to 21 million Americans a year would benefit from legislation waiving preexisting condition exclusions for individuals who have maintained continuous health care coverage. In addition, perhaps as many as 4 million Americans who at some time have been unwilling to leave their employer because of concerns about losing their health care coverage would benefit from the proposed legislation. However, although premium increases are possible, the insurance industry's response to such reforms remains unclear.

Ryan White CARE Act: Access to Services by Minorities, Women, and Substance Abusers (Testimony, 7/17/95, GAO/T-HEHS-95-212). Report on same topic (1/13/95, GAO/HEHS-95-49).

GAO found that minorities, women, and injection drug users generally use services at a rate that reflect their representation in the human immunodeficiency virus (HIV)-infected population in the five locations visited. Service providers and advocates of HIV-infected people in these communities agreed with this assessment of the patient population receiving Ryan White Comprehensive AIDS Resources Emergency Act (CARE)-funded services. Nonetheless, these HIV-infected groups may have to rely on Ryan White CARE Act-funded services more so than other subpopulations. Therefore, there may still be unmet needs for care. Providers and advocates described barriers to care that are particularly difficult to overcome, such as homelessness, substance abuse, and language and cultural differences. Providers mentioned the importance of outreach to help overcome these barriers.

Medicare Managed Care: Enrollment Growth Underscores Need to Revamp HMO Payment Methods (Testimony, 7/12/95, GAO/T-HEHS-95-207).

The recent enrollment growth in Medicare HMO has been rapid and accelerating. This growth adds to the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers capture from HMOs. Alternative methods of determining HMO rates have been suggested, but little experience exists on how well these methods would work under Medicare. GAO derived two lessons from reviewing ways to fix Medicare's HMO capitation payment: (1) With respect to rate-setting, one size does not fit all, and (2) with respect to achieving initiatives for improving the capitation payment, details matter in determining the difference between

success and failure. Although HCFA is planning demonstration projects to study ways to correct its HMO rate-setting method, results are likely to be at least several years away. HCFA can mitigate its capitation rate problem by introducing a better health status risk adjuster. HCFA should also proceed promptly to test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs.

Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (Testimony, 7/12/95, GAO/T-HEHS-95-206).

Requiring states to obtain waivers to broaden use of managed care may hamper their efforts to aggressively pursue cost-containment strategies. At the same time, because current program restrictions on managed care were designed to reinforce quality assurance, their absence requires the substitution of appropriate and adequate mechanisms to protect both Medicaid beneficiaries and federal dollars. Finally, the reinvestment of managed care savings to expand Medicaid coverage to several million additional individuals suggests the need for up-front consultation with the Congress because of (1) the heavier financial burden that such 1115 waivers may place on the federal government and (2) the issue of whether the U.S. Treasury should benefit from those savings.

## Other Health Products

Treatment of Hardcore Cocaine Users (Letter, 7/31/95, GAO/HEHS-95-179R).

Impact of Organ Allocation Variances (Letter, 7/31/95, GAO/HEHS-95-203R).

Medicaid: Local Contributions (Letter, 7/28/95, GAO/HEHS-95-215R).

Hospital-Based Home Health Agencies (Letter, 7/19/95, GAO/HEHS-95-209R).

Medicare: Allegations Against ABC Home Health Care (Testimony, 7/19/95, GAO/T-OSI-95-18). Report on same topic (7/19/95, GAO/OSI-95-17).

Superfund: Information on Current Health Risks (Report, 7/19/95, GAO/RCED-95-205).

Medicare Providers' Legal Expenses (Letter, 7/18/95, GAO/HEHS-95-214R).

Reassignment of Two NIH Employees (Letter, 7/5/95, GAO/OSI-95-14R).

# Education

## Selected Summaries

Vocational Education: 2-Year Colleges Improve Programs, Maintain Access for Special Populations (Report, 7/26/95, GAO/HEHS-95-163).

As 2-year colleges have enhanced their vocational-technical programs, their efforts have reflected many of the priorities outlined in the Perkins amendments. Colleges appear to have moved aggressively to increase their use of performance measures—such as placement rates, program completion rates, and results from state licensing exams—in program assessments. In addition, 3 years after the passage of the Perkins amendments, nearly all colleges in our sample indicated that they either offer or are developing tech-prep programs. Other desired changes, however, have been slower to develop. The removal of the set-aside requirement in the Perkins amendments has not adversely affected enrollments of special-population students. Special-population students enrolled in 2-year colleges to the same extent in fall 1990 and fall 1993, and participation by special-population students in vocational-technical programs remained virtually unchanged over this period. Furthermore, colleges reported either increasing or maintaining the availability of support services for special-population students.

Vocational Education: Changes at High School Level After Amendments to Perkins Act (Report, 7/12/95, GAO/HEHS-95-144).

The 1990 amendments to the Perkins Act removed a requirement that funds be set aside for students from special populations. Some individuals expressed concern that removal of the set-aside requirement would hurt these student groups. However, GAO found that removal of the set-aside requirement for students from special-population groups did not inhibit their participation, limit the availability of services, or affect their postgraduation status. In addition, Both signs of progress and room for improvement exist as secondary schools and school districts have acted to modernize and enhance their vocational education programs. Schools have moved aggressively to apply some approaches but have been slower to adopt other changes. Teacher training in integrating vocational and academic instruction also increased, but the majority of schools in GAO's survey did not employ several practices (team teaching, for example) that bring integrated learning concepts into the classroom. School districts also reported increased use of quality indicators (such as placement data) in

their self-assessment processes, despite the difficulties many of them encounter in gathering this kind of information.

Student Financial Aid: Data Not Fully Utilized to Identify Inappropriately Awarded Loans and Grants (Report, 7/11/95, GAO/HEHS-95-89).

Although continuing to face billions of dollars in annual payments for defaulted student loans, the Department of Education has, in general, ineffectively used available student aid data to enforce compliance with federal requirements. Further, the Department has not effectively used other data that could identify students who received (1) grants while attending two or more schools concurrently or (2) additional financial aid despite being ineligible because they had defaulted on previous loans. GAO found instances in which oversight responsibilities were divided and data ineffectively shared by units in the Office of Postsecondary Education. In early 1995, these weaknesses were addressed when the Department made improvements to its organizational structure. The Department has initiated a series of improvements to its student loan and grant systems. These include developing new systems, implementing data controls in its existing systems, and strengthening program reviews at schools.

# Employment

## Selected Summaries

Employment Discrimination: Most Private-Sector Employers Use Alternative Dispute Resolution (Report, 7/5/95, GAO/HEHS-95-150).

To determine the extent of the use of alternative dispute resolution (ADR) approaches, GAO sent a questionnaire to a stratified, random sample of 2,000 businesses that had (1) filed equal employment opportunity (EEO) reports with the Equal Employment Opportunity Commission (EEOC) in 1992 and (2) reported having more than 100 employees. GAO estimates, on the basis of the questionnaire results, that almost all employers with 100 or more employees use one or more ADR approaches. Arbitration is one of the least common approaches reported. Some employers using arbitration make it mandatory for all workers. Employer policies on arbitrating discrimination complaints vary considerably in form and level of detail. However, some of these policies, such as those for employees obtaining information and empowering the arbitrator to use remedies equal to those under law, would not meet standards of fairness proposed recently by the

Commission on the Future of Worker-Management Relations, which was established by the Secretary of Labor and the Secretary of Commerce at the President's request.

# Social Security, Disability, and Welfare

## Selected Summaries

Illegal Aliens: National Net Cost Estimates Vary Widely (Report, 7/25/95, GAO/HEHS-95-133).

Three national studies concluded that illegal aliens in the United States generate more in costs than revenues to federal, state, and local governments combined. However, their estimates of the national net cost varied considerably, ranging from $2 billion to $19 billion. Because little data are available on illegal aliens' use of public services and tax payments, the various indirect approaches used to estimate costs and revenues were often based on assumptions whose reasonableness is unknown. Moreover, the studies varied considerably in the range of costs and revenues they included and their treatment of certain items, making them difficult to compare. GAO found that a relatively small number of costs and revenues account for much of the variation in the estimates of the national net cost of illegal aliens. Better data on the illegal alien population and clearer explanations of which costs and revenues are appropriate to include would help improve the usefulness of estimates of the national net cost.

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (Report, 7/7/95, GAO/HEHS-95-137).

Since the mid-1980s, a variety of changes in the Supplemental Security Income (SSI) program have made benefits available to a broader population. Both congressional actions and court decisions have allowed a wider range of impairments to qualify as disabilities, notably for mentally impaired adults and for children. Also, the Congress has mandated increased outreach and publicity efforts to help overcome barriers to getting SSI. Meanwhile, some disabled recipients may stay on SSI longer and receive larger benefits than they would otherwise because the program has devoted little effort to checking that recipients continue to be disabled and helping them return to work. Since these program changes began, the

SSI recipient population has changed dramatically; disabled recipients now account for nearly 80 percent of federal SSI payments. Three groups have accounted for nearly 90 percent of SSI's growth since 1991—adults with mental impairments, children, and noncitizens. SSI recipients now tend to be younger, stay on SSI longer, receive larger benefits, and depend more on SSI as a primary source of income.

## Other Social Security, Disability, and Welfare Products

OHA Backlogs (Letter, 7/28/95, GAO/HEHS-95-228R).

Welfare to Work: State Programs Have Tested Some of the Proposed Reforms (Report, 7/14/95, GAO/PEMD-95-26).

# Veterans Affairs and Military Health

## Selected Summaries

Defense Health Care: Problems With Medical Care Overseas Are Being Addressed (Report, 7/12/95, GAO/HEHS-95-156).

Since the downsizing of the American military presence in Europe began in 1989, beneficiaries have generally found it more difficult to obtain health services at military facilities. Beneficiaries have access to primary care, but for some, particularly non active-duty beneficiaries, access to specialty care varies and is often inconvenient. Military medical personnel must overcome many obstacles to provide the care that is offered. These personnel are hampered by staff shortages, long waits for laboratory test results, and equipment failures. The reduced military health care system has resulted in the Department of Defense's (DOD) placing a greater reliance on the German and Italian medical system for providing treatment to beneficiaries. Beneficiaries, however, must contend with language barriers, cultural differences, unfamiliar doctors, quality of care concerns, and a general lack of information about obtaining host nation care. To address these problems and concerns, DOD has taken or is planning to take a number of actions.

VA Health Care: Physician Peer Review Identifies Quality of Care Problems but Actions to Address Them Are Limited (Report, 7/7/95, GAO/HEHS-95-121).

The peer review process at the six Department of Veterans Affairs (VA) medical centers that GAO visited has enabled the facilities to identify potential quality of care problems. However, actions taken by VA clinical service chiefs to address these problems were often limited to undocumented discussions with the physicians involved. Peer review in both VA and non-VA facilities is a highly subjective process that relies heavily on professional judgment. While experts recognize that some element of professional judgment will always be present in peer review, the development of practice guidelines and use of peer review by committee can help to reduce it. By establishing restrictive procedures for reporting to the National Practitioner Data Bank, VA medical centers are not reporting to the Data Bank many of the malpractice payments made on behalf of physicians, dentists, and other licensed health care practitioners or the adverse actions taken against physicians' and other practitioners' clinical privileges.

# Health (Comprehensive 1-Year Listing)

## Access and Infrastructure

Ryan White Care Act: Access to Services by Minorities, Women, and Substance Abusers (Testimony, 7/17/95, GAO/T-HEHS-95-212). Report on same topic (1/13/95, GAO/HEHS-95-49).

Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry (Report, 8/5/94, GAO/HEHS-94-220).

## Employee and Retiree Health Benefits

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (Report, 7/25/95, GAO/HEHS-95-167). Testimony on same topic (7/25/95, GAO/T-HEHS-95-223).

## Financing

Health Insurance For Children: Many Remain Uninsured Despite Medicaid Expansion (Report, 7/19/95, GAO/HEHS-95-175).

Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (Testimony, 7/18/95, GAO/T-HEHS-95-205).

Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (Report, 6/12/95, GAO/HEHS-95-161FS).

Ryan White Care Act of 1990: Opportunities Are Available to Improve Funding Equity (Testimony, 4/5/95, GAO/T-HEHS-95-126). Testimony on same topic (2/22/95, GAO/T-HEHS-95-91). Correspondence on same topic (2/14/95, GAO/HEHS-95-79R, and 3/31/95, GAO/HEHS-95-119R).

German Health Reforms: Changes Result in Lower Health Costs in 1993 (Report, 12/16/94, GAO/HEHS-95-27).

Biotech R & D, Reform, and Market Change (Letter, 12/15/94, GAO/HEHS-95-34R).

Hospital Costs: Cost Control Efforts at 17 Texas Hospitals (Report, 12/9/94, GAO/AIMD-95-21).

Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems (Report, 10/3/94, GAO/HEHS-95-1).

Insurance Ratings: Comparison of Private Agency Ratings for Life/Health Insurers (Report, 9/29/94, GAO/GGD-94-204BR).

Hospital Compensation: Nationally Representative Data on Chief Executives' Compensation (Report, 8/16/94, GAO/HEHS-94-189).

Health Insurance For The Elderly: Owning Duplicate Policies Is Costly and Unnecessary (Report, 8/3/94, GAO/HEHS-94-185).

## Health Care Reform Related Issues

Cost of Health Care Task Force Related Activities (Testimony, 3/14/95, GAO/T-GGD-95-114).

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (Report, 9/29/94, GAO/HEHS-94-219).

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (Report, 9/22/94, GAO/HEHS-94-173).

Small Business: SBA's Health Care Reform Activities (Report, 9/6/94, GAO/RCED-94-240).

## HHS Public Health Service Agencies

Practice Guidelines: Overview of Agency for Health Care Policy and Research Efforts (Testimony, 7/25/95, GAO/T-HEHS-95-221).

Reassignment of Two NIH Employees (Letter, 7/5/95, GAO/OSI-95-14R).

Immunization: HHS Could Do More to Increase Vaccination Among Older Adults (Report, 6/8/95, GAO/PEMD-95-14).

Health and Human Services: Opportunities to Realize Savings (Testimony, 1/12/95, GAO/T-HEHS-95-57).

Food and Drug Administration: Carrageenan Food Additive From the Philippines Conforms to Regulations (Report, 8/2/94, GAO/HEHS-94-141).

## Long-Term Care and Aging

Immunization: HHS Could Do More to Increase Vaccination Among Older Adults (Report, 6/8/95, GAO/PEMD-95-14).

Long-Term Care: Current Issues and Future Directions (Report, 4/13/95, GAO/HEHS-95-109).

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1994 (Report, 12/29/94, GAO/HEHS-95-44).

Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages (Report, 11/7/94, GAO/HEHS-95-26).

Long-Term Care Reform: States' Views on Key Elements of Well-Designed Programs for the Elderly (Report, 9/6/94, GAO/HEHS-94-227).

Long-Term Care: Other Countries Tighten Budgets While Seeking Better Access (Report, 8/30/94, GAO/HEHS-94-154).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (Report, 8/11/94, GAO/HEHS-94-167).

## Managed Care

Medicare Managed Care: Enrollment Growth Underscores Need to Revamp HMO Payment Methods (Testimony, 7/12/95, GAO/T-HEHS-95-207).

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (Testimony, 5/24/95, GAO/T-HEHS-95-174).

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (Report, 5/4/95, GAO/HEHS-95-138). Testimony on same topic (5/4/95, GAO/T-HEHS-95-143).

Defense Health Care: DOD's Managed Care Program Continues to Face Challenges (Testimony, 3/28/95, GAO/T-HEHS-95-117).

## Medicare and Medicaid

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (Testimony, 7/31/95, GAO/T-HEHS-95-227).

Medicaid: Local Contributions (Letter, 7/28/95, GAO/HEHS-95-215R).

Medicare: Enhancing Health Care Quality Assurance (Testimony, 7/27/95, GAO/T-HEHS-95-224).

Medicaid: Matching Formula's Performance and Potential Modifications (Testimony, 7/27/95, GAO/T-HEHS-95-226).

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (Testimony, 7/19/95, GAO/T-HEHS-95-211).

Health Insurance For Children: Many Remain Uninsured Despite Medicaid Expansion (Report, 7/19/95, GAO/HEHS-95-175).

Medicare: Allegations Against ABC Home Health Care (Testimony, 7/19/95, GAO/T-OSI-95-18). Report on same topic (7/19/95, GAO/OSI-95-17).

Medicare Providers' Legal Expenses (Letter, 7/18/95, GAO/HEHS-95-214R).

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# Employment (Comprehensive 1-Year Listing)

## Equal Employment Opportunities

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# Social Security, Disability, and Welfare (Comprehensive 1-Year Listing)

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# Social Security and Disability

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# Veterans Affairs and Military Health (Comprehensive 1-Year Listing)

## Military Health Care

Defense Health Care: Problems With Medical Care Overseas Are Being Addressed (Report, 7/12/95, GAO/HEHS-95-156).

Operation Desert Storm: Health Concerns of Selected Indiana Persian Gulf War Veterans (Report, 5/16/95, GAO/HEHS-95-102).

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