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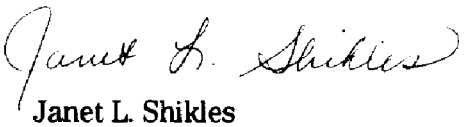
Preface

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 [formerly the Human Resources Division (HRD)] reviews the government's health, education, employment, and income security 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.



Janet L. Shikles
Assistant Comptroller General

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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 Income
DOD	Department of Defense
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
NAGB	National Assessment Governing Board, Department of Education
NTID	National Technical Institute for the Deaf
OIG	Office of Inspector General
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 (October 1993 - February 1994)

Health

Selected Summaries

Health Care Reform: Implications of Geographic Boundaries for Proposed Alliances (Testimony, 2/24/94, GAO/T-HEHS-94-108).

A common feature of many health reform bills is the creation of health-purchasing groups, commonly called alliances, which pool risks and have the market power of a large group of purchasers. Three major bills incorporate alliances. Decisions on alliance boundaries are left to the states except for provisions in all three bills that require Metropolitan Statistical Areas (MSA) remain intact. There is some potential that procedures for defining MSA and alliance boundaries could become political decisions that might affect existing health markets. The three issues often raised in regard to the drawing of alliance boundaries are (1) the impact on the provision of care, (2) the potential concentration of higher-risk populations, and (3) the redistribution of health care costs.

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.

Health Care in Hawaii: Implications for National Reform (Report, 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 to 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.

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.

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).

Although state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the insurance market and varies widely among states. State insurance departments perform a variety of regulatory activities to protect consumers from insurer failures, unfair policy provisions, excessive premiums, and unscrupulous insurer business practices. However, each state insurance department's role in regulating health insurance is affected by its legal framework and regulatory philosophy. The resources state legislatures allocate to their insurance departments and the proportion the departments dedicate to regulating health insurance also varies among states. In analyzing various health care reform proposals, the Congress needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers.

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.

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

To obtain nationally representative data on hospital chief executive compensation, GAO surveyed 429 hospitals participating in the federal Medicare program. In 1991, hospital chief executives received an average of $131,000, with a median of $114,541, in compensation for overseeing hospital operations. Overall, one-fourth of the chief executives earned less than $63,000, while an equal number earned more than $178,000. Differences in compensation amounts can largely be explained by differences in hospital characteristics, inpatient data, financial performance, and location. The actual amount of compensation reported to GAO is understated by the amount of income the chief executives receive for services to related businesses.

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

The Public Employees' Retirement System (CalPERS) record of controlling the growth of health insurance premiums for participating employers has improved since 1992, outperforming most other employers. The recent trend toward slower growth in premiums, due in part to the weakened California economy, followed several years in which the average CalPERS premium increased at rates near or above nationwide averages. Several factors contributed to the System's success. CalPERS incorporates many features of a "health alliance" as proposed under managed competition in health care reform.

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

In fiscal year 1993, Medicare cost $146 billion, covered about 35 million beneficiaries, and processed about 700 million claims. Medicare expenditures are expected to increase to $259 billion by 1998. Due to budgeting and management problems, the government pays too little attention to the activities protecting Medicare benefit dollars and is losing opportunities to save many millions of dollars in Medicare payments. The Health Care Financing Administration (HCFA) faces management challenges that compound funding reduction problems.

Veterans Affairs: Service Delays at VA Outpatient Facilities (Testimony, 10/27/93, GAO/T-HRD-94-5). Testimony on same topic (7/21/93, GAO/T-HRD-93-29). Report on same topic (10/15/93, GAO/HRD-94-4).

Veterans have experienced lengthy delays when they receive medical care in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA). Veterans frequently waited one to three hours before having their nonurgent conditions examined by a physician in VA's screening clinics. Inefficient operating practices are major contributors to veterans' service delays. To be a viable competing provider under health reform as proposed by President Clinton, VA needs to quickly restructure its outpatient delivery system to provide more timely ambulatory services.

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).

In 1993, Germany instituted reforms to tighten existing cost-control measures. Before 1993, Germany had budget caps for the physician and hospital sectors that were negotiated between the associations representing providers and the sickness funds. These funds provide health insurance to most Germans. The initial thrust of the 1993 reforms was government-imposed mandatory global budgets for three years. These generally limit the growth of expenditures in the physician and hospital sectors to the rate of increase of the revenues of the sickness funds. Global budgets were also instituted for the first time on the pharmaceutical and dental sectors. The government's goal is to stabilize contribution rates and save over $6 billion the first year. Additional cost-containment measures are in various stages of development and are expected to reduce continued reliance on global budgets. Early indications

are that expenditures are being reduced. Some critics, however, assert that the quality of care will be compromised as costs are squeezed.

Other Health Products

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).

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

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).

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

Nuclear Health and Safety: Examples of Post World War II Radiation Releases at U.S. Nuclear Sites (Report, 11/24/93, GAO/RCED-94-51FS).

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

Department of Veterans Affairs Appropriation (Letter, 11/12/93, GAO/HRD-94-57R).

VA Health Care: Tuberculosis Control Receiving Greater Emphasis at VA Medical Centers (Report, 11/9/93, GAO/HRD-94-5).

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

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

Automating Medical Information (Letter, 10/22/93, GAO/AIMD-94-47R).

VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans (Report, 10/15/93, GAO/HRD-94-4).

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).

VA Health Care: Medical Care Cost Recovery Activities Improperly Funded (Report, 10/12/93, GAO/HRD-94-2)

Education

Selected Summaries

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.

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

The National Technical Institute for the Deaf (NTID) has not adequately accounted for its expenditure of federal funds, has inappropriately carried over federal funds from one year to the next, and may have used federal funds improperly. However, because NTID commingled its federal funds with its nonfederal funds, it is impossible to determine how federal funds were spent. Financial audits of NTID have been limited in scope and review of NTID's programs and operations has been minimal. NTID has taken action to ensure that its federal funds are used properly. The Education of the Deaf Act Amendments of 1992 and 1993 include provisions to enhance the Department of Education's monitoring of NTID's spending and use of federal funds.

Other Education Products

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

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

States' Regulatory Reform Efforts (Letter, 11/3/93, GAO/HRD-94-51R).

Student Financial Aid Programs: Pell Grant Program Abuse (Testimony, 10/27/93, GAO/T-OSI-94-8).

Academy Preparatory Schools (Letter, 10/5/93, GAO/NSIAD-94-56R).

Employment

Selected Summaries

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-administrered 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.

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

Many separatees and their spouses are not getting timely transition services as required by law. This has happened because the program has not received adequate support from DOD, military service headquarters, and from individual military and unit commanders. As a result, (1) officials responsible for providing transition services did not know who was separating, (2) separating service members were not being provided information on translating their military experience and training into marketable civilian skills, (3) members were either not being provided individual preseparation counseling or were not receiving timely counseling, and (4) many service members and their spouses did not have the opportunity to attend transition seminars and use employment assistance centers.

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

The assistance provided to workers dislocated by the 1978 expansion of Redwood National Park was quite extensive, but few workers enrolled in retraining programs. Many workers received generous wage replacement benefits or severance payments, but these benefits were not tied to retraining. Humbolt and Del Norte were the two California counties most affected by the park expansion. Economically, Humbolt County remained relatively stable during the transition, while the Del Norte County experienced more fluctuations. Del Norte's economy did not stabilize until Pelican Bay state prison was built in the county in 1989.

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.

Dislocated Workers: Trade Adjustment Assistance Program Flawed (Testimony, 10/19/93, GAO/T-HRD-94-4).

Each year, approximately 1 million experienced workers lose their jobs due to business closures and permanent layoffs. Many of these workers are dislocated because of increased imports. Some workers receive assistance from the Trade Adjustment Assistance (TAA) program to help them re-enter the workforce. GAO, Department of Labor, and Mathematica studies conclude that the TAA program falls short of its goal of assisting dislocated workers to re-enter the workforce.

Other Employment Products

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

Dislocated Workers: Proposed Re-employment Assistance Program (Report, 11/12/93, GAO/HRD-94-61).

U.S.-Mexico Trade: The Work Environment at Eight U.S.-Owned Maquiladora Auto Parts Plants (Report, 11/1/93, GAO/GGD-94-22).

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

Income Security

Selected Summaries

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.

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.

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

State programs under the Supplemental Food Program for Women, Infants, and Children (WIC) have substantially increased their breastfeeding promotional efforts since the 1989 reauthorization of the WIC program. Local WIC sites we visited integrated breastfeeding education into their nutrition education services. Increasing the rate of breastfeeding among WIC participants may not lower total WIC food costs appreciably, even if the total amount of formula purchased is reduced. Between 1989 and 1992, the incidence of breastfeeding in-hospital increased nearly 12 percent among

WIC participants, compared with 5 percent among nonparticipants, according to data from the Ross Laboratories' Mothers Survey.

Social Security: Increasing Number of Disability Claims and Deteriorating Service (Report, 11/10/93, GAO/HRD-94-11). Testimony on same topic (3/25/93, GAO/T-HRD-93-11).

Claim backlogs and processing times for Social Security DI and SSI programs reached an all-time high infiscal year 1992. GAO found that between 1990 and 1992 these backlogs and processing times increased nearly 50 percent. Some states take more than five months to process claims. SSA and the states' disability determination services (DDS) have not been able to keep up with the high rate of claims submitted for benefits. Problems resulting from increased workloads include increased work force stress and use of overtime, employees not performing their normal duties, a decline in workforce morale, an increase in claims being set aside, and a decline in automated systems support.

Social Security: Sustained Effort Needed to Improve Management and Prepare for the Future (Report, 10/27/93, GAO/HRD-94-22). Testimony on same topic (10/28/93, GAO/T-HRD-94-46).

This is the third in a series of GAO reports assessing SSA's effectiveness in preparing for the future and managing current operations. This report assesses SSA's progress in making improvements to its strategic management, information resource management, human resource management, and financial management systems. Failure to meet SSA's management challenges could have serious consequences. SSA currently provides benefits to about 47 million people, and the agency will have to provide benefits and services to many more people in the future.

State and Local Finances: Some Jurisdictions Confronted by Short- and Long-Term Problems (Report, 10/6/93, GAO/HRD-94-1). Testimony on same topic (10/6/93, GAO/T-HRD-94-1).

From 1985 to 1991, state and local governments faced a challenge in responding to varied spending and revenue pressures. This led jurisdictions to reevaluate their spending priorities, control program growth, cut some services, and increase revenues. GAO identified several large cities that faced not only a short-term problem of budget deficits, but also a long-term deterioration in the public services they provide.

Other Income Security Products

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

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

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).

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).

Disabled Veterans Programs: U.S. Eligibility and Benefit Types Compared With Five Other Countries (Report, 11/24/93, GAO/HRD-94-6).

D.C. Pension Benefits (Report, 11/4/93, GAO/HRD-94-18).

Armed Forces Retirement Home (Letter, 11/3/93, GAO/HRD-94-49R).

DOD Military Disability Retirement (Report, 11/3/93, GAO/HRD-94-50R).

Foster Care: Federal Policy on Title IV-E Share of Training Costs (Report, 11/3/93, GAO/HRD-94-7).

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).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Letter, 3/12/92, GAO/HRD-92-27R).

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).

Summary Information on Farmworkers (Letter, 4/10/92, GAO/HRD-92-30R).

Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (Testimony, 3/11/92, GAO/T-GGD-92-20). Report with same title (2/12/92, GAO/GGD-92-37).

Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (Report, 3/10/92, GAO/HRD-92-40).

Financing

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).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Testimony, 4/28/92, GAO/T-GGD-92-15). Report on same topic (3/19/92, GAO/GGD-92-44).

Early Intervention: Federal Investments Like WIC Can Produce Savings (Report, 4/7/92, GAO/HRD-92-18).

Maternal and Child Health: Block Grant Funds Should Be Distributed More Equitably (Report, 4/2/92, GAO/HRD-92-5).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Report, 3/19/92, GAO/GGD-92-44).

Health Care Reform Related Issues

Health Care Reform: Implications of Geographic Boundaries for Proposed Alliances (Testimony, 2/24/94, GAO/T-HEHS-94-108).

Health Care in Hawaii: Implications for National Reform (Report, 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 Lodine 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).

Over the Counter Drugs: Gaps and Potential Vulnerabilities in the Regulatory System (Testimony, 4/28/92, GAO/T-PEMD-92-8). Report on same topic (1/10/92, GAO/PEMD-92-9).

Nonprescription Drugs: Over the Counter and Underemphasized (Testimony, 4/8/92, GAO/T-PEMD-92-5).

FDA Premarket Approval: Process of Approving Olestra as a Food Additive (Report, 4/7/92, GAO/HRD-92-86).

FDA Premarket Approval: Process of Approving Ansaid as a Drug (Report, 4/7/92, GAO/HRD-92-85).

FDA Regulations: Sustained Management Attention Needed to Improve Timely Issuance (Testimony, 4/1/92, GAO/T-HRD-92-19). Report with same title (2/21/92, GAO/HRD-92-35).

Long-Term Care

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).

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (Report, 3/27/92, GAO/HRD-92-66).

HHS Staff for Board and Care Issues (Letter, 4/1/92, GAO/HRD-92-29R).

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).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, 4/10/92, GAO/T-HRD-92-26).

Medicare and Medicaid

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).

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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).

Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, 7/20/93, GAO/HRD-93-93).

Medicaid Estate Planning (Letter, 7/20/93, GAO/HRD-93-29R).

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, 6/23/93, GAO/T-NSIAD-93-16).

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (Report, 5/18/93, GAO/HRD-93-70).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (Report, 5/13/93, GAO/IMTEC-93-18).

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

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (Report, 4/30/93, GAO/HRD-93-86).

Screening Mammography: Higher Medicare Payments Could Increase Costs Without Increasing Use (Report, 4/22/93, GAO/HRD-93-50).

Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (Testimony, 4/20/93, GAO/T-HRD-93-14). Report on same topic (5/27/92, GAO/HRD-92-59).

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (Testimony, 4/2/93, GAO/T-HRD-93-13).

Medicaid Formula Alternatives (Letter, 3/31/93, GAO/HRD-93-18R). Letter on same topic (3/2/93, GAO/HRD-93-17R).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (Report, 3/18/93, GAO/HRD-93-55FS).

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Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (Report, 1/15/93, GAO/HRD-93-43).

High-Risk Series: Medicare Claims (Report, 12/92, GAO/HR-93-6).

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Medicaid: Disproportionate Share Policy (Letter, 12/22/92, GAO/HRD-93-3R).

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

Medicare: HCFA Monitoring of the Quality of Part B Claims Processing (Testimony, 9/23/92, GAO/T-PEMD-92-14).

Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud and Abuse (Testimony, 9/10/92, GAO/T-HRD-92-56).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (Report, 8/26/92, GAO/HRD-92-76).

D.C. Government: District Medicaid Payments to Hospitals (Report, 8/24/92, GAO/GGD-92-138FS).

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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).

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Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (Report, 6/12/92, GAO/HRD-92-64).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (Report, 5/27/92, GAO/HRD-92-59).

Medicare: Contractor Oversight and Funding Need Improvement (Testimony, 5/21/92, GAO/T-HRD-92-32).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, 4/10/92, GAO/T-HRD-92-26).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (Report, 3/18/92, GAO/IMTEC-92-41). Testimony on same topic (3/18/92, GAO/T-IMTEC-92-11).

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Medicaid Third-Party Liability (Letter, 3/3/92, GAO/HRD-92-21R).

Military Health Care

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

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (Report, 9/20/93, GAO/HRD-93-149).

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DOD Mental Health Review Efforts (Letter, 3/31/93, GAO/HRD-93-19R).

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Major Contributors

David W. Bieritz
Angela D. Bridges
Susan Y. Higgins
James L. Kirkman
Stephen F. Palincsar

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