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Health
Education
Employment
Social Security
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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 2 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

AFDC	Aid to Families With Dependent Children
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRS	Congressional Research Service, Library of Congress
DC	District of Columbia
DI	Social Security Disability Insurance
DOD	Department of Defense
DODDS	Department of Defense Dependents Schools
DOE	Department of Energy
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
ERISA	Employee Retirement Income Security Act of 1974
ESEA	Elementary and Secondary Education Act
FDA	Food and Drug Administration
GAO	General Accounting Office
GME	Graduate Medical Education

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
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JOBS	Job Opportunities and Basic Skills program
NAGB	National Assessment Governing Board, Department of Education
OBRA	Omnibus Budget Reconciliation Act of 1990
OSHA	Occupational Safety and Health Administration
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
SBHC	school-based health center
SSA	Social Security Administration
TRICARE	DOD nationwide managed health care program
USDA	United States Department of Agriculture
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 (April - May 1994)

Health

Selected Summaries

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (Report, 5/23/94, GAO/HEHS-94-66).

Since 1989, the Health Care Financing Administration (HCFA) tried to reduce administrative costs by urging Medicare contractors to share claims processing system software and hardware with other contractors. In October 1991, Blue Cross and Blue Shield of Maryland began using claims processing software developed by another contractor. For more than a year after the system conversion, Medicare payments to Maryland physicians were frequently late and often contained errors, resulting in unanticipated costs of more than $5 million. The Maryland contractor has yet to realize any of the anticipated annual savings of more than $600,000 in administrative costs. Poor management by Blue Cross and Blue Shield of Maryland and poor decisions by HCFA contributed to the contractor's costly and turbulent conversion.

Primary Care Physicians: Managing Supply in Canada, Germany, Sweden, and the United Kingdom (Report, 5/18/94, GAO/HEHS-94-111).

The four countries reviewed use health policies and other strategies to manage physician resources. They attempt to manage their physician resources as one of many methods to contain health care costs. Unlike the United States, the countries reviewed have national targets or goals for the supply and mix of physicians. To achieve these goals, the countries' regulatory strategies include managing (1) medical school enrollment, (2) specialist training slots, and (3) physician employment opportunities. Canada, Sweden, and the United Kingdom try to manage physician resources in underserved areas. The approaches they have tried include (1) limiting the number of physicians practicing in overserved areas, (2) offering financial incentives, and (3) assigning medical student trainees to work in rural areas.

Prescription Drugs: Spending Controls in Four European Countries (Report, 5/17/94, GAO/HEHS-94-30).

To reduce the growth of pharmaceutical costs, the four countries we studied—France, Germany, Sweden, and the United Kingdom—have employed a variety of national policies. These policies have

largely—though not exclusively—targeted drug manufacturers. The policies appear to have been effective at restraining drug prices, but they have been unable to prevent continued increases in drug spending. Pressures to reduce growth in prescription drug expenditures have spurred efforts to make patients and physicians more aware of drug prices and more financially responsible for drug spending. In pursuing cost containment, each country has encountered a tension between low drug prices and pharmaceutical research.

Health Care Reform: School-Based Health Centers Can Promote Access to Care (Report, 5/13/94, GAO/HEHS-94-166).

Our work suggests that school-based health centers (SBHC) do improve children's access to health care. SBHCs around the nation face a common set of problems, including (1) lack of a stable source of funding, (2) not always having sufficient resources, and (3) difficulty in obtaining reimbursement from public and private insurers. Furthermore, local debates over the appropriateness of providing reproductive health services in SBHCs have constrained centers' ability to meet some adolescents' health needs. Federal health care reform that increases access to insurance coverage could alleviate some of the problems faced by SBHCs. However, reform that includes expansion of the role of managed care networks may exacerbate financing problems because of the reluctance of these networks to reimburse SBHCs.

Medicaid Prenatal Care: States Improve Access and Enhance Services, but Face New Challenges (Report, 5/10/94, GAO/HEHS-94-152BR).

Most states have used Medicaid to improve access to prenatal care services, and many have also enhanced the prenatal care services reimbursable through Medicaid. Health care delivery for low-income women and children is changing. States are increasingly enrolling their low-income pregnant women and children in managed medical care, and, at the same time, state and national health care reform may be imminent. Enrolling women in managed care plans does not ensure that women are entering care, getting the services they need, nor having healthy births. Content of care and access to services are important to improving outcomes. Health care reform may remove Medicaid as a financing mechanism for more enhanced services to many currently eligible pregnant women.

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (Report, 5/6/94, GAO/HEHS-94-147). Testimony on same topic (5/6/94, GAO/T-94-167).

The Department of Health and Human Services (HHS) has been directed to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents who are covered by employer-provided health insurance. The goal is to save millions by strengthening processes to (1) identify the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage for medical bills before Medicare and Medicaid coverage begins and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs. In GAO's view, however, the data bank will end up costing millions, be a burden on employers, and likely achieve little savings.

Medicare: Graduate Medical Education Payment Policy Needs to Be Reexamined (Report, 5/5/94, GAO/HEHS-94-33).

Medicare pays for about 29 percent of the total direct costs of Graduate Medical Education (GME). These payments, which amounted to $1.46 billion in 1992, are intended to compensate hospitals for Medicare's share of the costs associated with training physicians. For the 1989-91 period, our analysis showed that about 60 percent of interns and residents were training in nonprimary care specialties, versus about 40 percent in primary care specialties. However, our analysis also showed that the proportion of interns and residents categorized as nonprimary care physicians changed from 60 to 75 percent when we considered those who ultimately completed their primary care training and entered practice as nonprimary care physicians.

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

Because Public Health Service agencies' programs often address the same diseases or conditions, the potential exists for the agencies to duplicate each other's activities. The Congress wanted to ensure it did not fund duplicate programs and activities. Congressional concerns have also been raised about expanding the funding for the Centers for Disease Control and Prevention (CDC), which rose from $587 million to about $1.5 billion between fiscal years 1987 and 1992. Concerns have likewise been raised that the scope of CDC's programs and activities today extends well beyond

the agency's early focus on communicable disease. GAO found that no PHS agency was duplicating another agency's public health activities in the programs GAO reviewed. Also, CDC's programs were appropriate considering the agency's legislative authority and its history of prevention and control efforts regarding chronic diseases and other health conditions.

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (Report, 4/29/94, GAO/HEHS-94-42).

HCFA does not monitor Medicare carriers' postpayment analyses and often misses opportunities to identify millions of dollars in excessive payments. Medicare carriers use claims data to identify billing abuses and excessive payments for health care services. However, Medicare carriers often use inaccurate data in compiling statistical reports on physicians and other providers. HCFA also has failed to provide carriers with appropriate analysis methods and does not assess the extent that carriers' recovery efforts and payment controls save program costs or deter future abuses. Funds allotted for postpayment review have not kept pace with the growth of Medicare claims. HCFA needs to expand guidance and technical assistance for carriers and establish relevant measures to assess carriers' performance.

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

One issue being raised in the debate over health care reform is how antitrust law should be applied to health care providers. Federal and state antitrust law seeks to prevent price fixing and predatory pricing and to ensure access to and quality of goods and services for consumers. Since 1974, Maryland has operated a rate-setting program that sets how much hospitals can charge for their services. Also, health care facilities operating in Maryland must obtain a certificate of need if they wish to change the type of services they provide or to make major capital expenditures. To the extent that the state actively regulates hospitals, federal antitrust enforcement concerning such regulated activities may not be relevant under the Supreme Court's state action immunity doctrine.

Medicare: Impact of OBRA-90's Dialysis Provision on Providers and Beneficiaries (Report, 4/25/94, GAO/HEHS-94-65).

To control soaring Medicare costs, Congress has required that, in some cases, employer-sponsored group health plans covering Medicare

beneficiaries pay medical claims before Medicare. Since 1981, such a requirement has been in place for patients with advanced kidney disease, which requires regular dialysis or a kidney transplant. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) extended the period during which these plans must pay before Medicare will pay. The OBRA extension of the plans' obligation as primary payers has increased the amount that providers receive for dialysis by an estimated $41 million per year. This increase occurred because employer-sponsored plans generally pay dialysis providers more than the cost-based Medicare rates.

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

Volunteer ambulance companies often transport Medicare patients to hospitals. In some cases, the patient may require the services of a paramedic trained in advanced life support services. GAO found that Medicare contractors rely on states to certify ambulance companies for participation in the Medicare program, and states set their own certification requirements. Most volunteer ambulance companies do not charge for their services nor have their own paramedics. Medicare does not pay separately for paramedics, who are covered only if they are an integral part of the ambulance service. Although data are limited, GAO believes that the potential liability of Medicare beneficiaries for paramedic services may be substantial.

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.

Other Health Products

Health Care: Benefits and Barriers to Automated Medical Records (Testimony, 5/6/94, GAO/T-AIMD-94-117).

FDA Drug Enforcement Actions (Letter, 5/6/94, GAO/HEHS-94-136R).

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

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).

Education

Selected Summaries

Higher Education: Grants Effective at Increasing Minorities' Chances of Graduating (Testimony, 5/17/94, GAO/T-HEHS-94-168).

As college tuition has soared during the past 15 years, grant aid to students has not kept pace, and loans account for an ever-increasing proportion of student aid. However, our preliminary results indicate that grant aid is more likely than loan aid to improve graduation rates for some minorities. For both African-American and Hispanic students, grants significantly reduced the probability of dropping out, but loans did not. The shift in federal funding from grants to loans may save federal budget dollars initially but could cost the economy in the long run. Although the federal

cost of a grant exceeds that of a loan of an equivalent amount, grants may be more cost-effective if they better encourage students to finish their college education and, as a result, boost their earnings potential.

Early Childhood Programs: Many Poor Children and Strained Resources Challenge Head Start (Report, 5/17/94, GAO/HEHS-94-169BR).

The number of children under age five who are at risk of school failure increased greatly during the 1980s. Education reform and the reauthorization of Head Start—the centerpiece of federal early childhood programs—have focused attention on improving the quality of early childhood programs and increasing the number of children being served. This report highlights the major themes and policy implications for implementing Head Start and other early childhood programs. GAO concludes that efforts to improve the quality of the Head Start program and expand it to include more children are complicated by several factors: the growing numbers and changing characteristics of poor children, rising costs of services, and limited community resources.

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.

Regulatory Flexibility in Schools: What Happens When Schools Are Allowed to Change the Rules? (Report, 4/29/94, GAO/HEHS-94-102).

To enable school principals and teachers to attempt improvements in education, the federal government and some state governments have provided flexibility to schools as part of education reform initiatives by both reducing or eliminating regulations for schools through government action, such as legislative change, and waiving specific regulations upon

request on a case-by-case basis. Under some state regulations, for example, a teacher might be discouraged from shortening the time devoted to some subjects—such as driver's education—to provide more in-depth coverage of difficult subjects—such as calculus. GAO studied the regulatory flexibility efforts of California, Kentucky, and South Carolina.

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.

Other Education Products

Delta Teachers Academy (Letter, 5/19/94, GAO/RCED-94-213R).

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).

Employment

Other Employment Products

Federal Employment: H.R. 4361, Federal Employees Family Friendly Leave Act (Testimony, 5/18/94, GAO/T-GGD-94-152).

Social Security and Welfare

Selected Summaries

Families on Welfare: Teenage Mothers Least Likely to Become Self-Sufficient (Report, 5/31/94, GAO/HEHS-94-115).

Women who gave birth as teenagers make up nearly half of the Aid to Families with Dependent Children (AFDC) caseload—a sizeable group. Our analysis shows that this group of women is less likely to have high school diplomas and more likely to have larger families. Both these characteristics increase the likelihood of being among the poorest AFDC recipients. As the Congress considers welfare reform, it may need to explore preventative strategies aimed at discouraging young mothers from becoming dependent on welfare and encouraging those that do to become self-sufficient.

Families on Welfare: Focus of Teenage Mothers Could Enhance Welfare Reform Efforts (Report, 5/31/94, GAO/HEHS-94-112).

AFDC families headed by women who have either less than a high school education, little recent work experience, or children younger than age 6 are likely to leave AFDC less quickly than other families. These characteristics are especially prevalent among teenage mother receiving AFDC. Being a teenage mother has long-term implications for the welfare system. Together, current and former teenage mothers make up a large percentage of the AFDC caseload and are among the poorest AFDC recipients. As part of welfare reform, the Job Opportunities and Basic Skills (JOBS) program's targeting efforts could be enhanced by narrowing its focus on the youngest parents—teenagers—rather than all recipients under age 24 with little education or work experience.

Families on Welfare: Sharp Rise in Never-Married Women Reflects Societal Trend (Report, 5/31/94, GAO/HEHS-94-92).

Compared to 1976, single women receiving AFDC in 1992 were more likely to have never-married, to have a high school diploma and to have fewer children. These demographic changes paralleled similar trends among all single mothers. Single women receiving AFDC in 1992 were poorer than in 1976, even though they worked in about the same proportions. Characteristics of the group of never-married women receiving AFDC also changed. In 1992, never-married women receiving AFDC were less likely to be teenage mothers and more likely to have a high school diploma. The dramatic growth in the number of never-married women receiving AFDC is not unique to women receiving AFDC, but rather reflects a broader societal trend among all women. It is thus unclear what impacts proposed changes to the AFDC program may have on the growth in the number and proportion of never-married women receiving AFDC.

Social Security Disability: Most of Gender Difference Explained (Report, 5/27/94, GAO/HEHS-94-94).

Relative to their numbers in the population of workers insured for Social Security benefits, older as well as younger women received Disability Insurance (DI) benefits at lower rates than men. This is understandable because women apply for benefits at a lower rate than men. However, in older age groups, women who apply for benefits are also allowed benefits at a lower rate. The type and severity of impairment and the demographic characteristics we analyzed explained about two-thirds of the gender

difference in allowance rates for older applicants of DI benefits. We are unable to explain about one-third of the gender difference in initial decisions. We found no evidence of bias in initial decisions.

Federal Aid: Revising Poverty Statistics Affects Fairness of Allocation Formulas (Report, 5/20/94, GAO/HEHS-94-165).

Concerns have been raised in the Congress that revising counts of people in poverty by adjusting the official poverty line for geographic difference in the cost of living could significantly alter the allocation of federal aid to state and local governments. This report presents GAO's views on how such a revision could affect the fairness of the distribution of federal formula grants. GAO concludes that adjusting poverty counts to reflect differences in the cost of living, if proven feasible, would bolster the federal government's ability to target federal aid to places with the greatest needs. GAO also believes that such a change should not be implemented in federal allocation formulas without also assessing the need to better reflect other dimensions of state funding needs such as state funding capabilities.

Social Security: Major Changes Needed for Disability Benefits for Addicts (Report, 5/13/94, GAO/HEHS-94-128). Testimony on same topic (2/10/94, GAO/T-HEHS-94-101).

The number of addicts receiving disability benefits has grown substantially in the last 5 years—from fewer than 100,000 to about 250,000. The cost of providing disability benefits to the current addict population is about $1.4 billion per year. The vast majority of addicts receiving disability benefits either are not in treatment or their treatment status is unknown. About 100,000 addicts have not been assigned a third-party or representative payee to manage their benefits. Consequently, SSA has no assurance that these individuals are not using their benefit checks to buy drugs or alcohol. We believe that SSA needs to act to ensure that all drug addiction and alcohol recipients are in treatment and that all addicts have a third-party or representative payee.

Child Care: Working Poor and Welfare Recipients Face Service Gaps (Report, 5/13/94, GAO/HEHS-94-87).

In response to the growing number of working mothers with young children, Congress created four new child care programs for low-income families. These programs received more than $1.5 billion in federal funding in fiscal year 1992. Although states are making strides toward coordination

of these federally funded child care programs, some federal requirements, coupled with resource constraints, are creating gaps in the delivery of child care services to both welfare recipients and the working poor. Since welfare recipients who are working or in training and recent welfare recipients who are working are entitled by law to child care subsidies, in an environment of finite resources, there is pressure to serve these individuals while equally needy working poor individuals may go unaided. State officials believe that they would be better able to deliver child care that supports self-sufficiency if greater consistency existed across programs and if they had greater flexibility in how they spend their federal child care funds.

Older Americans Act: Funding Formula Could Better Reflect State Needs (Report, 5/12/94, GAO/HEHS-94-41).

In response to congressional concerns that current title III allocations do not fully reflect indicators of states' needs, GAO examined the interstate funding formula of the current Older Americans Act of 1965. This formula allocated more than $770 million in federal title III dollars in fiscal year 1993 among the 50 states and the District of Columbia. GAO concludes that the Congress should modify the formula for distributing title III money to better target those elderly persons with the greatest social and economic needs.

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.

Other Social Security & Welfare Products

Lead-Based Paint Poisoning: Children in Section 8 Tenant-Based Housing Are Not Adequately Protected (Report, 5/13/94, GAO/RCED-94-137).

Homelessness: McKinney Act Programs Provide Assistance but Are Not Designed to Be the Solution (Report, 5/94, GAO/RCED-94-37).

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).

Veterans Affairs and Military Health

Selected Summaries

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (Testimony, 5/5/94, GAO/T-HEHS-94-148).

The veterans' health care provisions of the Health Security Act address many of the issues discussed in our reports. GAO believes that eligibility reforms that enable VA to shift the focus of its health care system from inpatient to ambulatory and primary care and its collateral plans to become an increasingly managed care system are long overdue steps. Several financial and policy implications, however, need to be considered by the Congress. For example, the expanded entitlement to free comprehensive health care benefits could add billions of dollars to Department of Veterans Affairs (VA) appropriations if all veterans entitled to free care seek to enroll in VA health plans. Authorizing the Secretary of Veterans Affairs to offer supplemental benefit policies covering such services as long-term nursing care could add tens of billions of dollars to VA appropriations.

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 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.

Other Veterans and Military Health Products

VA and the Health Security Act (Letter, 5/9/94, GAO/HEHS-94-159R).

Medical Records Control (Letter, 5/4/94, GAO/HEHS-94-161R).

Health (Comprehensive 2-Year Listing)

Access and Infrastructure

Primary Care Physicians: Managing Supply in Canada, Germany, Sweden, and the United Kingdom (Report, 5/18/94, GAO/HEHS-94-111).

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).

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).

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 Care Reform Related Issues

Health Care Reform: School-Based Health Centers Can Promote Access to Care (Report, 5/13/94, GAO/HEHS-94-166).

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

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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).

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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).

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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).

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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).

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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).

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

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Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (Report, 5/23/94, GAO/HEHS-94-66).

Medicaid Prenatal Care: States Improve Access and Enhance Services, but Face New Challenges (Report, 5/10/94, GAO/HEHS-94-152BR).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (Report, 5/6/94, GAO/HEHS-94-147). Testimony on same topic (5/6/94, GAO/T-HEHS-94-162).

Medicare: Graduate Medical Education Payment Policy Needs to be Reexamined (Report, 5/5/94, GAO/HEHS-94-33).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (Report, 4/29/94, GAO/HEHS-94-42).

Medicare: Impact of OBRA-90's Dialysis Provision on Providers and Beneficiaries (Report, 4/25/94, GAO/HEHS-94-65).

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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).

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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).

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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).

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