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PREFACE

The May 1993 issue of Health Reports is a list of health products including reports and testimonies issued by the General Accounting Office (GAO) over the past 2 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health product. Reports and testimonies on the same topic may be combined into a single entry.

The first section--Recent GAO Products--summarizes reports and testimonies on selected health issues published from January through April 1993. This section is followed by a list of additional products published during the same period and then a section listing summaries of most frequently requested health reports. The remainder of Health Reports is a list of health products published from May 1991 through April 1993 organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. An order form to be placed on our mailing list for Health Reports is on page 48 of this report. An order form to request GAO products is on page 49.

TABLE OF CONTENTS

Abbreviations

ADMS	Alcohol, Drug Abuse and Mental Health Services
ADP	automatic data processing
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DC	District of Columbia
DOD	Department of Defense
DOE	Department of Energy
FDA	Food and Drug Administration
GAO	General Accounting Office
GPO	group purchasing organization
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
IHS	Indian Health Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OBRA	Omnibus Budget Reconciliation Act of 1990
OSHA	Occupational Safety and Health Administration
R & D	research and development
RBRVS	Medicare Resource-Based Relative Value Scale
USDA	United States Department of Agriculture
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

RECENT GAO PRODUCTS
(Jan. - Apr. 1993)

SUMMARIES OF SELECTED REPORTS

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

In assessing the organ allocation and procurement system, GAO found that existing practices raise questions as to equity of organ allocation decisions. The lack of an adequate measure of organ procurement effectiveness hinders efforts to monitor and improve organ procurement. Although the National Organ Procurement and Transplantation Network has improved the procurement and allocation of organs for transplant, further improvements are needed.

Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (Testimony, Apr. 20, 1993, GAO/T-HRD-93-14). Report on same topic (May 27, 1992, GAO/HRD-92-59).

Freestanding diagnostic imaging centers have proliferated in many parts of the country and are also among the most popular types of physician-owned joint ventures. Referral practices for diagnostic imaging varied among the medical specialties. GAO's study of diagnostic imaging referral practices provides further evidence that physician investment in medical facilities is associated with more frequent referral to those facilities and higher health care costs.

Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention (Report, Apr. 9, 1993, GAO/HRD-93-48).

GAO reviewed the availability of health care services to American Indians and Alaska Natives residing in five Indian Health Service (IHS) areas--Aberdeen, Alaska, California, Navajo, and Portland. While they differed greatly in the way they delivered health care services, the five areas reported generally similar availability of basic clinical services. Service units officials generally identified alcohol and substance abuse services as their greatest unmet health need. IHS lacks data on alcoholism rates among Indians and the effectiveness of current prevention and treatment programs. Without such data, IHS is hard pressed to develop effective strategies that maximize the use of its limited resources.

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (Testimony, Apr. 2, 1993, GAO/T-HRD-93-13).

Beginning in 1980, the Congress enacted a number of laws making Medicare the secondary payer for most beneficiaries covered under employer-sponsored group health insurance. These amendments have reduced Medicare costs by billions of dollars. Medicare has had problems recouping funds from other insurers when it discovers that it has mistakenly paid for the services for which another insurer was liable. GAO believes opportunities exist to identify a more efficient and less costly approach to identify Medicare secondary payer activities.

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (Report, Mar. 30, 1993, GAO/HRD-93-86).

GAO found that use of the Texas disproportionate share program formula favors public hospitals that receive a relatively large amount of state and local revenue. The formula does not give full credit to hospitals' charity care that is not tax supported--such as that provided by some private hospitals. Four other states--Florida, Louisiana, Michigan, and Virginia--reviewed by GAO have established qualifying formulas which include a measure of charity care provided to low-income patients.

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Report, Mar. 24, 1993, GAO/HRD-93-41). Testimony on same topic (June 1, 1992, GAO/T-HRD-92-36).

Most state Medicaid programs could save money if low-cost vaccines acquired through Centers for Disease Control and Prevention (CDC) contracts were made available to all health care providers administering vaccinations to poor children. Savings on vaccine costs, however, will do little to improve preschool immunization levels unless funds are provided for educating parents and tracking and following up on the immunization status of children to help ensure that preschool children receive timely immunizations. Most states do not systematically carry out these three activities.

Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy (Report, Mar. 23, 1993, GAO/HRD-93-60).

The Yale University forecasting model, which GAO found to be credible, estimated a 33 percent reduction in new HIV infections among New Haven, Connecticut, needle exchange program participants over one year. Despite the potential of such programs as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of exchange programs. Only

three of nine needle exchange programs reviewed by GAO had published results showing changes in needle sharing behaviors based on strong evidence. Two of these three programs reported a reduction in needle sharing while a third reported an increase. Five programs found that injection drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use.

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (Report, Mar. 18, 1993, GAO/HRD-93-55FS).

Nine pharmacies in Illinois and Maryland received about 19 percent more Medicaid reimbursement for selected drugs than the total amount paid for these drugs by the pharmacies. For the Illinois pharmacies, the amount by which reimbursements exceeded purchase costs ranged from 10 to 23 percent. For the Maryland pharmacies, the range was from 11 to 34 percent.

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (Report, Mar. 17, 1993, GAO/HRD-93-46). Testimony on same topic (Mar. 17, 1993, GAO/T-HRD-93-10).

Most states are rapidly developing or expanding their managed care programs. States choosing managed care for their Medicaid programs report facing difficult implementation issues. Medicaid managed care plans have had mixed results in improving access to care, assuring the quality of services, and saving money. States moving to managed care are under increasing pressure to monitor access and quality of services to ensure that providers' medical decisions are not compromised by financial incentives.

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Health insurance experts estimate that fraud and abuse contribute to some 10 percent of the $800-plus billion currently spent on health care. Overcoming obstacles, which frustrate insurers' efforts to prevent or detect and pursue cases involving fraudulent or abusive billing, will require systematic collaboration by insurers, law enforcement agents, regulators, and providers, on problems involving health insurance fraud and abuse. Resource constraints add to the problems of pursuing health care fraud.

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (Testimony, Feb. 22, 1993, GAO/T-HRD-93-5). Report with same title (Sept. 30, 1992, GAO/HRD-92-110).

Drug manufacturers typically charge wholesalers in the United States more than those in Canada. U.S./Canadian price differentials for 121 widely dispensed drugs sold in both countries varied significantly. These price differences can be explained largely by two factors that manufacturers encounter in Canada but not in the United States: (1) federal regulations are designed to restrain drug prices, and (2) provincial drug benefit plans pay for drugs for a large segment of the population.

Prescription Drug Prices: Analysis of Canada's Patented Medicine Prices Review Board (Report, Feb. 17, 1993, GAO/HRD-93-51).

Canadian federal strategy for limiting prescription drug prices relies largely on the Patented Medicine Prices Review Board to determine when the price of a patented drug is excessive and to apply sanctions, when necessary, against drug manufacturers. The Board has the power, following a public hearing, to order the removal of market exclusivity or a price reduction if it finds a price to be excessive. Canadian experience shows that a drug price review board can restrain prescription drug prices. The Board's effect on Canadian pharmaceutical research and development (R & D) is in dispute.

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (Testimony, Feb. 17, 1993, GAO/T-HRD-93-4).

Medicare's soaring expenditures underscore the need for the government to fund and manage the program judiciously. Despite a 12-to-1 return on money invested in payment safeguards (payment control activities), contractors' per claim funding for payment safeguards has declined by over 24 percent since 1989. The Medicare program is also suffering from management weaknesses. The Health Care Financing Administration (HCFA) has not compiled information on contractors' payment safeguard controls and cannot systematically identify where important controls may be needed. In addition, HCFA has not always provided adequate guidance to contractors on such matters as recovering overpayments and investigating complaints alleging fraud and abuse.

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, Feb. 4, 1993, GAO/T-HRD-93-3). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

The size of the health care sector and sheer volume of money involved make it an attractive target for fraud and abuse. Profiteers are able to stay ahead of those who pay claims, in part, because of the obstacles to preventing and pursuing dishonest practices. Once detected, fraud is expensive and time-consuming to pursue. Limited resources can constrain state and federal prosecutors from pursing health care cases involving relatively small dollar amounts. Without adequate resources, the two significantly involved federal agencies cannot effectively investigate and pursue health care fraud cases. Due to the complexity of health care structural issues, GAO asked the Congress to consider establishing a national commission to develop comprehensive solutions to health insurance fraud and abuse.

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Rochester, New York, has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. Rochester residents are more likely to have health insurance than populations of other cities and the nation. Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. Rochester's planning initiatives have included limiting the expansion of hospital capacity, implementing global budgeting that capped total hospital revenues, and controlling the diffusion of medical technology.

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (Report, Jan. 15, 1993, GAO/HRD-93-43).

Price changes experienced by health maintenance organizations (HMOs) and group purchasing organizations (GPOs) that we studied varied considerably since the enactment of Medicaid rebate provisions in the Omnibus Budget Reconciliation Act of 1990 (OBRA). Some prices increased substantially, while others declined. HMO and GPO representatives were concerned that OBRA would reduce the substantial price discounts off average wholesale price they traditionally received from manufacturers. HMOs and GPOs also reported changes in how they contract for drug prices with many manufacturers. The purchasers were concerned that these contract changes created uncertainty about future drug prices because they provided manufacturers more flexibility to increase prices.

Major Issues Facing a New Congress and a New Administration (Testimony, Jan. 8, 1993, GAO/T-OCG-93-1).

Escalating health care costs, which have created crises in funding for many social programs and reforms, as well as long-term strategies to contain costs, are among the major issues facing the new Congress and the new President.

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Nationwide, from 1985 through 1990, emergency department patient caseloads grew dramatically. Growth was concentrated among patients whose medical care is often not reimbursed, such as Medicaid in some states, and the uninsured. This disproportionate growth may make it more difficult for hospitals to absorb or offset losses due to unreimbursed emergency department patient care costs. Nationwide patterns of caseload growth, payer mix, and timeliness of care conceal substantial variations in emergency department conditions among hospitals.

LIST OF ADDITIONAL GAO HEALTH PRODUCTS ISSUED BETWEEN JANUARY AND APRIL 1993

VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (Report, Apr. 30, 1993, GAO/HRD-93-39).

Social Security: Rising Disability Rolls Raise Questions (Testimony, Apr. 22, 1993, GAO/T-HRD-93-15).

Cataract Surgery: Patient-Reported Data on Appropriateness and Outcomes (Testimony, Apr. 21, 1993, GAO/T-PEMD-93-3). Report on same topic (Apr. 20, 1993, GAO/PEMD-93-14).

FDA Premarket Approval: Process of Approving Lodine as a Drug (Report, Apr. 12, 1993, GAO/HRD-93-81).

Public Health Service: Evaluation Set-Aside Has Not Realized Its Potential to Inform the Congress (Report, Apr. 8, 1993, GAO/PEMD-93-13).

Long-Term Care Case Management: State Experiences and Implications for Federal Policy (Report, Apr. 6, 1993, GAO/HRD-93-52).

Potential Effects of Health Financing Reforms on Demand for VA Services (Testimony, Mar. 31, 1993, GAO/T-HRD-93-12).

Medicaid Formula Alternatives (Letter, Mar. 31, 1993, GAO/HRD-93-18R).

Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals (Report, Mar. 18, 1993, GAO/HRD-93-10).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (Testimony, Mar. 3, 1993, GAO/T-HRD-93-7).

Medicaid Formula Alternative (Letter, Mar. 2, 1993, GAO/HRD-93-17R).

VA Health Care: Selection of a Planned Medical Center in East Central Florida (Report, Mar. 1, 1993, GAO/HRD-93-77).

VA Health Care: Actions Needed to Control Major Construction Costs (Report, Feb. 26, 1993, GAO/HRD-93-75).

Veterans Disability: Information from Military May Help VA Assess Claims Related to Secret Tests (Report, Feb. 18, 1993, GAO/NSIAD-93-89).

Childhood Immunizations (Letter, Feb. 8, 1993, GAO/HRD-93-12R).

Environmental Tobacco Smoke (Letter, Feb. 8, 1993, GAO/RCED-93-77R).

Family and Medical Leave Cost Estimate (Letter, Feb. 1, 1993, GAO/HRD-93-14R).

Health Information Systems: National Practitioner Data Bank Continues to Experience Problems (Report, Jan. 29, 1993, GAO/IMTEC-93-1).

MOST FREQUENTLY REQUESTED HEALTH REPORTS

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (Report, Sept. 30, 1992, GAO/HRD-92-110).

Manufacturers' prices to wholesalers for identical prescription drugs are typically higher in the United States than in Canada. The price differences are largely attributable to actions taken by Canada's federal and provincial governments to restrain drug prices, not to any differences in manufacturers' costs in the two countries. The implications of adopting Canadian regulations in the United States are in dispute. It is not clear how such regulations would affect manufacturers' ability to develop innovative drug products.

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Many employers are facing rapidly increasing health insurance premiums and are frustrated by their unsuccessful efforts to contain health care costs. Firms most vulnerable to rising health costs are those whose health insurance plans offer extensive benefits and cover a large number of retirees or dependents; those whose workers are older, less healthy, or earning higher incomes; those with relatively few workers; and those in high health-cost areas. Individual firms can do little to lower their health care costs because they cannot readily change their size, location, or employee demographics.

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA). This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (Report, May 27, 1992, GAO/HRD-92-59).

In some localities, Medicare's technical component payments for Magnetic Resonance Imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and higher machine utilization. Current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding excess capacity to the health care system.

Access to Health Insurance: State Efforts to Assist Small Businesses (Report, May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

GAO found that most states have proposed or already implemented programs to try to expand small business employees' access to health insurance coverage. Many of these initiatives have been adopted within the past 2 years, but the early indications are that they have led to only modest gains in the number of firms offering health insurance. This is largely because costs have not been reduced sufficiently to induce small firms to offer health insurance.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. GAO has asked the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of public and private payers and to build consensus among representatives of divergent viewpoints.

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Report, Dec. 26, 1991, GAO/HRD-92-14).

The National Association of Insurance Commissioners (NAIC) model standards for long-term care insurance provide greater consumer

protection than existed before 1986. However, consumers are still vulnerable to considerable risks. GAO discusses additional standards that are necessary to improve consumer protection. Moreover, if states do not adopt NAIC standards, Congress may wish to consider enacting legislation that sets minimum federal standards for long-term care insurance.

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

France, Germany and Japan achieve near-universal health insurance coverage. This report describes these countries' health insurance and financing method, their policies intended to restrain health care spending increases, and the effectiveness of these policies. While GAO does not endorse the specific health systems in the reviewed countries, their strengths and weaknesses could be instructive in helping resolve U.S. health care problems.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (Report, June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

This report contains testimony presented to the House Committee Ways and Means on April 17, 1991, on health care costs in the United States as well as on long-term strategies for reform of the U.S. health care system.

Canadian Health Insurance: Lessons for the United States (Report, June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are currently uninsured. There would be enough left over to permit a reduction, or possibly even the elimination, of copayments and deductibles. With the authority and responsibility to oversee the system as a whole, as in Canada, the single payer could potentially constrain the growth in long-run health care costs. Canadians have few problems with access to primary care services. The Canadian method of controlling hospital costs has limited the use of expensive, high technology diagnostic and surgical procedures.

HEALTH FINANCING AND ACCESS

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Major Issues Facing a New Congress and a New Administration (Testimony, Jan. 8, 1993, GAO/T-OCG-93-1).

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, Feb. 4, 1993, GAO/T-HRD-93-3). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Transition Series: Health Care Reform (Report, Dec. 1992, GAO/OCG-93-STR).

Removal of Breast Implants (Letter, Dec. 7, 1992, GAO/HRD-93-5R).

Bone Marrow Transplants: National Program Has Greatly Increased Pool of Potential Donors (Report, Nov. 4, 1992, GAO/HRD-93-11).

Trauma Care Reimbursement: Poor Understanding of Losses and Coverage for Undocumented Aliens (Report, Oct. 15, 1992, GAO/PEMD-93-1).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Hospital Costs: Adoption of Technologies Drives Cost Growth (Report, Sept. 9, 1992, GAO/HRD-92-120).

State Health Care Reform: Federal Requirements Influence State Reforms (Testimony, Sept. 9, 1992, GAO/T-HRD-92-55). Report on same topic (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (Testimony, July 28, 1992, GAO/T-HRD-92-49).

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (Report, May 28, 1992, GAO/HRD-92-73FS).

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (Report, May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Testimony, Apr. 28, 1992, GAO/T-GGD-92-15). Report on same topic (Mar. 19, 1992, GAO/GGD-92-44).

Early Intervention: Federal Investments Like WIC Can Produce Savings (Report, Apr. 7, 1992, GAO/HRD-92-18).

Maternal and Child Health: Block Grant Funds Should be Distributed More Equitably (Report, Apr. 2, 1992, GAO/HRD-92-5).

Health Care: Problems and Potential Lessons for Reform (Testimony, Mar. 27, 1992, GAO/T-HRD-92-23).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Report, Mar. 19, 1992, GAO/GGD-92-44).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Letter, Mar. 12, 1992, GAO/HRD-92-27R).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Report, Feb. 28, 1992, GAO/HRD-92-54).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Report, Feb. 13, 1992, GAO/HRD-92-36).

Budget Issues: 1991 Budget Estimates: What Went Wrong (Report, Jan. 15, 1992, GAO/OCG-92-1).

Hispanic Access to Health Care: Significant Gaps Exist (Report, Jan. 15, 1992, GAO/PEMD-92-6). Testimony on same topic (Sept. 19, 1991, GAO/T-PEMD-91-13).

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (Report, Sept. 27, 1991, GAO/PEMD-91-14).

States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements and Correct Problems (Testimony, Sept. 17, 1991, GAO/T-HRD-91-47).

Managed Care: Oregon Program Appears Successful But Expansion Should Be Implemented Cautiously (Testimony, Sept. 16, 1991, GAO/T-HRD-91-48).

Rural Hospitals: Closures and Issues of Access (Testimony, Sept. 4, 1991, GAO/T-HRD-91-46). Reports on same topic (Feb. 15, 1991, GAO/HRD-91-41), (June 19, 1990, GAO/HRD-90-134), (June 12, 1990, GAO/HRD-90-67).

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (Testimony, July 10, 1991, GAO/T-HRD-91-43). Report on same topic (May 30, 1990, GAO/HRD-90-84). Testimony on same topic (June 28, 1990, GAO/T-HRD-90-45).

Private Health Insurance: Problems Caused by a Segmented Market (Report, July 2, 1991, GAO/HRD-91-114). Testimony on same topic (May 2, 1991, GAO/T-HRD-91-21).

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (Report, June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

Canadian Health Insurance: Lessons for the United States (Report, June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors (Report, May 17, 1991, GAO/HRD-91-57).

Retiree Health: Company-Sponsored Plans Facing Increased Costs and Liabilities (Testimony, May 6, 1991, GAO/T-HRD-91-25).

MEDICARE AND MEDICAID

Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (Testimony, Apr. 20, 1993, GAO/T-HRD-93-14). Report on same topic (May 27, 1992, GAO/HRD-92-59).

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (Testimony, Apr. 2, 1993, GAO/T-HRD-93-13).

Medicaid Formula Alternatives (Letter, Mar. 31, 1993, GAO/HRD-93-18R).

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (Report, Mar. 30, 1993, GAO/HRD-93-86).

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (Report, Mar. 24, 1993, GAO/HRD-93-41). Testimony on same topic (June 1, 1992, GAO/T-HRD-92-36).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (Report, Mar. 18, 1993, GAO/HRD-93-55FS).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (Report, Mar. 17, 1993, GAO/HRD-93-46). Testimony on same topic (Mar. 17, 1993, GAO/T-HRD-93-10).

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (Testimony, Feb. 17, 1993, GAO/T-HRD-93-4).

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (Report, Jan. 15, 1993, GAO/HRD-93-43).

High-Risk Series: Medicare Claims (Report, Dec. 1992, GAO/HR-93-6).

Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans (Report, Dec. 31, 1992, GAO/HRD-93-31).

District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (Report, Dec. 29, 1992, GAO/HRD-93-28).

Medicaid: Disproportionate Share Policy (Letter, Dec. 22, 1992, GAO/HRD-93-3R).

Removal of Breast Implants (Letter, Dec. 7, 1992, GAO/HRD-93-5R).

Medicare: HCFA Monitoring of the Quality of Part B Claims Processing (Testimony, Sept. 23, 1992, GAO/T-PEMD-92-14).

Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud and Abuse (Testimony, Sept. 10, 1992, GAO/T-HRD-92-56).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (Report, Aug. 26, 1992, GAO/HRD-92-76).

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