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PREFACE

Health Reports is a list of health-related 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-related product. Reports and testimonies on the same topic may be combined into a single entry.

The first section--Recent GAO Health Products--summarizes reports and testimonies on selected health issues published during the past 4 months. 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-related products published during the past 2 years and organized by subject as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. Order forms to be placed on our mailing list for Health Reports and to request GAO products appear at the end of this publication.

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RECENT GAO HEALTH PRODUCTS
(June-September 1993)

SUMMARIES OF SELECTED REPORTS

Medical Malpractice: Estimated Savings and Costs of Federal Insurance at Health Centers (Report, Sept. 24, 1993, GAO/HRD-93-130).

The Federally Supported Health Centers Assistance Act of 1992 authorized the Department of Health and Human Services (HHS) to assume responsibility for medical malpractice claims involving community and migrant health centers under the Federal Tort Claims Act (FTCA) for 3 years. With a fully operating program, centers could save an estimated $55 million in insurance costs while the government's costs for claim payments could total an estimated $27 million for malpractice claims filed and closed between 1993 and 1995. However, because of the possible time lag between when an injury occurs and when a claim is filed and paid, it could take the government 10 or more years to pay for all the compensable injuries that occur at the centers while FTCA coverage is authorized. Over time it could cost the government considerably more money to resolve the centers' malpractice claims under FTCA than it would have cost to resolve the claims if the private sector's insurance coverage had continued, because the government provides a different type of coverage than that which most centers had purchased.

VA Health Care: Labor Management and Quality-of Care Issues at the Salem VA Medical Center (Report, Sept. 23, 1993, GAO/HRD-93-108).

GAO examined aspects of the quality assurance program; nursing and medical care provided; and management initiatives at the Salem, Virginia, Department of Veterans Affairs (VA) Medical Center. The review, in part, was prompted by the discovery of the bodies of two patients on the center's grounds. Personnel changes are restoring both staff and public confidence in the management of the facility. The new medical center director has begun to address quality-of-care concerns, labor management issues, and staffing shortages; however, more needs to be done. Longstanding problems have resulted in poor quality of care for some patients.

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (Report, Sept. 20, 1993, GAO/HRD-93-149).

The Department of Defense (DOD) certified the modified CHAMPUS Reform Initiative (CRI) as the most efficient method of health care delivery to eligible DOD beneficiaries in Washington and Oregon after comparing it with the standard CHAMPUS program. DOD does not, however, know how other health care delivery methods currently in operation or being tested in various parts of the country compare with the modified CRI program or standard CHAMPUS. As a

from the premiums they paid. In this study, sales commissions paid by companies for the first year of the policy averaged about 60 percent of the total value of the first year's premium. As reported previously in Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Report, Dec. 26, 1991, GAO/HRD-92-14), many states have not adopted the National Association of Insurance Commissioners (NAIC) model for reporting lapse rates and commission rates. State adoption of the NAIC provisions would strengthen monitoring of policies by state insurance commissioners and provide greater protection to consumers who buy them.

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, Aug. 11, 1993, GAO/HRD-93-126).

Medicare and Medicaid patients are less likely than other patients to file malpractice claims. When they file claims, their awards or settlements are significantly lower than those for patients with other health insurance. From October 1985 through September 1990, Medicare and Medicaid patients received about one-fourth of the $2.3 billion of hospital malpractice awards, although they represent more than 45 percent of hospital patients. While Medicare patients' percentage of hospital malpractice awards is significantly lower than their portion of hospital discharges, Medicaid patients' percentage is slightly higher than their discharge rate.

Preventive Health Care for Children: Experience From Selected Foreign Countries (Report, Aug. 4, 1993, GAO/HRD-93-62).

Although England, France, Germany, Japan, and the Netherlands provide universal access to health care for all children, they do not rely solely on systems of universal coverage to ensure that all children receive preventive services. Instead, these countries do one or more of the following: (1) notify health authorities of new births, (2) target new parents for home visits, (3) provide booklets for maintaining a child's health record, (4) provide physical exams and immunizations in schools, and (5) facilitate the continuity of care through computerized tracking systems.

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (Report, Aug. 2, 1993, GAO/HRD-93-118). Testimony on same topic (Aug. 2, 1993, GAO/T-HRD-93-28).

Twenty-one of the Medicaid Fraud Control Unit directors told GAO of problems involving drug diversion. Several factors, including data inadequacies and staff shortages, complicate attempts to curb drug diversion schemes. States are taking steps to address these problems, but despite local success stories, drug diversion persists. State agencies do not follow up cases of potential diversion. States and federal agencies also fail to use their authority to impose sanctions and recover program loses. Offenders

paid for under the orthotic and prosthetic fee schedule that do not require professional fabrication or fitting services. We also identified considerable variation in coverage criteria for braces and artificial limbs among Medicare's claims processing contractors. Medicare's December 1992 action to reduce the number of contractors that pay brace and artificial limb claims from 54 to 4 should remedy this problem and result in the use of more consistent criteria.

Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, July 20, 1993, GAO/HRD-93-93).

The Health Care Financing Administration (HCFA) actively sought and tested numerous data sources when developing the geographic adjusters and made reasonable data and methodology choices, considering the time constraints under which the adjusters were developed. We found that the Internal Revenue Service (IRS) has data available that could prove beneficial when the adjusters are updated. HCFA did not use IRS data in developing the current practice-cost adjuster because it did not believe that the technical and legal impediments to using these data could be overcome in the available time. Currently, HCFA is working with IRS to assess the feasibility of using IRS data in updating the adjusters.

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (Report, July 16, 1993, GAO/HRD-93-106).

Veterans' access to outpatient care at VA medical centers varies widely for two reasons: (1) medical centers interpret VA outpatient eligibility criteria differently and (2) medical centers' rationing decisions vary, including whether to ration and what rationing method to use. This variation results in veterans with similar medical conditions or income status receiving outpatient care at some medical centers but not at others.

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (Report, July 14, 1993, GAO/HRD-93-123).

Of 198 veterans surveyed, 168 (85 percent) obtained needed care after VA medical centers turned them away. These veterans received diagnostic evaluations or needed treatment, including medication, for the same conditions for which they had initially sought treatment at the VA centers. The remaining 30 veterans did not obtain further medical care, primarily because they could not afford it.

ADDITIONAL GAO HEALTH PRODUCTS ISSUED BETWEEN JUNE AND SEPTEMBER 1993

Drug Control: Reauthorization of the Office of National Drug Control Policy (Report, Sept. 29, 1993, GAO/GGD-93-144).

CDC's Mission and Duplication in PHS (Letter, Aug. 30, 1993, GAO/HRD-93-32R).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, Aug. 20, 1993, GAO/HRD-93-112FS).

Medical Technology: Quality Assurance Systems and Global Markets (Report, Aug. 18, 1993, GAO/PEMD-93-15).

Medicare Part B: Reliability of Claims Processing Across Four Carriers (Report, Aug. 11, 1993, GAO/PEMD-93-27).

Operation Desert Storm: Army Medical Supply Issues (Report, Aug. 11, 1993, GAO/NSIAD-93-206).

Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program (Report, July 28, 1993, GAO/NSIAD-93-189).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (Testimony, July 21, 1993, GAO/T-HRD-93-29).

Medicaid Estate Planning (Letter, July 20, 1993, GAO/HRD-93-29R).

Long-Term Care Forum (Discussion Paper, July 13-14, 1993, GAO/HRD-93-1-SP).

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (Report, July 9, 1993, GAO/HRD-93-125).

Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (Report, July 8, 1993, GAO/HRD-93-109).

Medical Readiness Training: Limited Participation by Army Medical Personnel (Report, June 30, 1993, GAO/NSIAD-93-205).

Federal Employment: Inquiry Into Sexual Harassment Issues at Selected VA Medical Centers (Report, June 30, 1993, GAO/GGD-93-119).

Federal Health Care: Increased Information Sharing Could Improve Service, Reduce Costs (Report, June 29, 1993, GAO/IMTEC-93-33BR).

Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (Report, June 25, 1993, GAO/PEMD-93-18).

MOST FREQUENTLY REQUESTED HEALTH REPORTS

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 are people living elsewhere in the nation. Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. These 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.

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

Nationwide emergency department patient caseloads grew dramatically from 1985 through 1990. Growth was concentrated among patients whose medical care is often not reimbursed, such as the uninsured and Medicaid patients in some states. 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.

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

public and private payers and to build consensus among representatives of divergent viewpoints.

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 methods, 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 April 17, 1991, testimony presented to the House Committee on Ways and Means 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 uninsured. Enough would be 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.

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).

MEDICARE AND MEDICAID

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (Report, Sept. 7, 1993, GAO/HRD-93-121).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, Aug. 20, 1993, GAO/HRD-93-112FS).

Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses (Report, Aug. 11, 1993, GAO/HRD-93-126).

Medicare Part B: Reliability of Claims Processing Across Four Carriers (Report, Aug. 11, 1993, GAO/PEMD-93-27).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (Report, Aug. 2, 1993, GAO/HRD-93-118).

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, July 21, 1993, GAO/HRD-93-98).

Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, July 20, 1993, GAO/HRD-93-93).

Medicaid Estate Planning (Letter, July 20, 1993, GAO/HRD-93-29R).

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, June 23, 1993, GAO/T-NSIAD-93-16).

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (Report, May 18, 1993, GAO/HRD-93-70).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (Report, May 13, 1993, GAO/IMTEC-93-18).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

Screening Mammography: Higher Medicare Payments Could Increase Costs Without Increasing Use (Report, Apr. 22, 1993, GAO/HRD-93-50).

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 Prescription Drug Diversion: A Major Problem, But State Approaches Offer Some Promise (Testimony, July 29, 1992, GAO/T-HRD-92-48).

Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy (Report, July 17, 1992, GAO/PEMD-92-28).

Resource-Based Relative Value Scale (RBRVS) and Administrative Costs (Letter, July 13, 1992, GAO/HRD-92-38R).

Medicare: Program and Beneficiary Costs Under Durable Medical Equipment Fee Schedules (Report, July 7, 1992, GAO/HRD-92-78).

Medicaid: Factors to Consider in Managed Care Programs (Testimony, June 29, 1992, GAO/T-HRD-92-43).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (Report, June 19, 1992, GAO/HRD-92-89).

Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs (Report, June 17, 1992, GAO/HRD-92-80).

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (Report, June 12, 1992, GAO/HRD-92-64).

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

Medicare: Contractor Oversight and Funding Need Improvement (Testimony, May 21, 1992, GAO/T-HRD-92-32).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, Apr. 10, 1992, GAO/T-HRD-92-26).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (Report, Mar. 18, 1992, GAO/IMTEC-92-41). Testimony on same topic (Mar. 18, 1992, GAO/T-IMTEC-92-11).

Medicare: Payments for Medically Directed Anesthesia Services Should Be Reduced (Report, Mar. 3, 1992, GAO/HRD-92-25).

Medicaid Third-Party Liability (Letter, Mar. 3, 1992, GAO/HRD-92-21R).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (Report, Feb. 21, 1992, GAO/HRD-92-52).

Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies (Report, Jan. 31, 1992, GAO/HRD-92-24).

MANAGED CARE

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiative (Testimony, May 10, 1993, GAO/T-HRD-93-21).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

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).

Medicaid: Factors to Consider in Managed Care Programs (Testimony, June 29, 1992, GAO/T-HRD-92-43).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (Report, June 19, 1992, GAO/HRD-92-89).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Testimony, Apr. 10, 1992, GAO/T-HRD-92-26).

Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (Report, Jan. 29, 1992, GAO/HRD-92-53).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (Testimony, Nov. 15, 1991, GAO/T-HRD-92-11). Report with same title (Nov. 12, 1991, GAO/HRD-92-11).

HEALTH QUALITY AND PRACTICE STANDARDS

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, Sept. 17, 1993, GAO/HRD-93-92).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

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).

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

VA Health Care: Medical Centers Are Not Correcting Identified Quality Assurance Problems (Report, Dec. 30, 1992, GAO/HRD-93-20).

Utilization Review: Information on External Review Organizations (Report, Nov. 24, 1992, GAO/HRD-93-22FS).

Health Care: Reduction in Resident Physician Work Hours Will Not Be Easy to Attain (Report, Nov. 20, 1992, GAO/HRD-93-24BR).

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey Home Health Agencies (Report, Oct. 26, 1992, GAO/HRD-93-33).

AIDS: CDC's Investigation of HIV Transmissions by a Dentist (Report, Sept. 29, 1992, GAO/PEMD-92-31).

Medical Technology: For Some Cardiac Pacemaker Leads, the Public Health Risks Are Still High (Report, Sept. 23, 1992, GAO/PEMD-92-20).

Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges (Report, July 16, 1992, GAO/HRD-92-98).

Screening Mammography: Federal Quality Standards Are Needed (Testimony, June 5, 1992, GAO/T-HRD-92-39).

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (Report, Apr. 20, 1992, GAO/HRD-92-93).

Cross Design Synthesis: A New Strategy for Medical Effectiveness Research (Report, Mar. 17, 1992, GAO/PEMD-92-18).

Medical Technology: Quality Assurance Needs Stronger Management Emphasis and Higher Priority (Report, Feb. 13, 1992, GAO/PEMD-92-10).

LONG-TERM CARE AND AGING

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (Report, Aug. 25, 1993, GAO/HRD-93-129).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, July 27, 1993, GAO/HRD-93-68).

Long-Term Care Forum (Discussion Paper, July 13-14, 1993, GAO/HRD-93-1-SP).

Long-Term Care Insurance: Tax Preferences Reduce Costs More for Those in Higher Tax Brackets (Report, June 22, 1993, GAO/GGD-93-110).

Massachusetts Long-Term Care (Letter, May 17, 1993, GAO/HRD-93-22R).

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

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1992 (Report, Dec. 23, 1992, GAO/HRD-93-57).

Long-Term Care Insurance Partnerships (Letter, Sept. 25, 1992, GAO/HRD-92-44R).

Elderly Americans: Nutrition Information Is Limited and Guidelines Are Lacking (Testimony, July 30, 1992, GAO/T-PEMD-92-11).

Public/Private Elder Care Partnerships: Balancing Benefit and Risk (Testimony, July 9, 1992, GAO/T-HRD-92-45). Report on same topic (July 7, 1992, GAO/HRD-92-94).

Older Americans Act: More Federal Action Needed on Public/Private Elder Care (Report, July 7, 1992, GAO/HRD-92-94).

Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor (Report, June 24, 1992, GAO/PEMD-92-29). Testimony on same topic (June 24, 1992, GAO/T-PEMD-92-10).

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (Testimony, June 23, 1992, GAO/T-HRD-92-44). Reports on same topic (Mar. 27, 1992, GAO/HRD-92-66 and Dec. 26, 1991, GAO/HRD-92-14). Testimonies on same topic (May 20, 1992, GAO/T-HRD-92-31 and Apr. 11, 1991, GAO/T-HRD-91-14).

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (Report, Mar. 27, 1992, GAO/HRD-92-66).

SUBSTANCE ABUSE AND DRUG TREATMENT

Drug Control: Reauthorization of the Office of National Drug Control Policy (Report, Sept. 29, 1993, GAO/GGD-93-144).

Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (Report, June 25, 1993, GAO/PEMD-93-18).

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

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

Prescription Drug Monitoring: States Can Readily Identify Illegal Sales and Use of Controlled Substances (Report, July 21, 1992, GAO/HRD-92-115).

Employee Drug Testing: Estimated Cost to Test All Executive Branch Employees and New Hires (Report, June 10, 1992, GAO/GGD-92-99).

Drug Control: Difficulties in Denying Federal Benefits to Convicted Drug Offenders (Report, Apr. 21, 1992, GAO/GGD-92-56).

Drug Education: Rural Programs Have Many Components and Most Rely Heavily on Federal Funds (Report, Jan. 31, 1992, GAO/HRD-92-34).

Adolescent Drug Use Prevention: Common Features of Promising Community Programs (Report, Jan. 16, 1992, GAO/PEMD-92-2).

Drug Abuse Research: Federal Funding and Future Needs (Report, Jan. 14, 1992, GAO/PEMD-92-5). Testimony on same topic (Sept. 25, 1991, GAO/PEMD-T-91-14).

ADMS Block Grant: Drug Treatment Services Could Be Improved by New Accountability Program (Report, Oct. 17, 1991, GAO/HRD-92-27). Testimony on same topic (Oct. 17, 1991, GAO/T-HRD-92-4).

MILITARY AND VETERANS HEALTH CARE

VA Health Care: Labor Management and Quality-of-Care Issues at the Salem VA Medical Center (Report, Sept. 23, 1993, GAO/HRD-93-108).

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (Report, Sept. 20, 1993, GAO/HRD-93-149).

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, Sept. 17, 1993, GAO/HRD-93-92).

Operation Desert Storm: Army Medical Supply Issues (Report, Aug. 11, 1993, GAO/NSIAD-93-206).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (Report, July 29, 1993, GAO/HRD-93-94).

Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program (Report, July 28, 1993, GAO/NSIAD-93-189).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, July 27, 1993, GAO/HRD-93-68).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (Testimony, July 21, 1993, GAO/T-HRD-93-29).

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (Report, July 16, 1993, GAO/HRD-93-106).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (Report, July 14, 1993, GAO/HRD-93-123).

Medical Readiness Training: Limited Participation by Army Medical Personnel (Report, June 30, 1993, GAO/NSIAD-93-205).

Federal Employment: Inquiry Into Sexual Harassment Issues at Selected VA Medical Centers (Report, June 30, 1993, GAO/GGD-93-119).

VA Health Care: Delays in Awarding Major Construction Contracts (Report, May 26, 1993, GAO/HRD-93-101).

DOD Health Care: Further Testing and Evaluation of Case-Managed Home Care Is Needed (Report, May 21, 1993, GAO/HRD-93-59).

VA Health Care: Problems in Implementing Locality Pay for Nurses Not Fully Addressed (Report, May 21, 1993, GAO/HRD-93-54).

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

VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (Report, Dec. 1, 1992, GAO/HRD-93-15).

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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).

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.

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

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, June 23, 1993, GAO/T-NSIAD-93-16).

Long-Term Care Insurance: Tax Preferences Reduce Costs More for Those in Higher Tax Brackets (Report, June 22, 1993, GAO/GGD-93-110).

1993 German Health Reforms: New Cost Control Initiatives (Report, July 7, 1993, GAO/HRD-93-103).

Sharp increases in the mandated health insurance premium paid by most workers and retirees triggered the 1993 German health care reforms. The government-imposed emergency global budget controls will remain in effect for the next 3 years to give the health care industry time to change the structure of the health care sector. These changes are expected to sufficiently reduce cost pressure so that federally imposed budget limits become unnecessary. The new reforms have initiatives to improve equity and stimulate competition in Germany's multiple third-party payer system. The reforms are expected to generate net savings of about $6.3 billion or about 6 percent of total sickness-fund spending in 1992.

FDA Regulation of Dietary Supplements (Letter, July 2, 1993, GAO/HRD-93-28R).

The Food and Drug Administration (FDA) regulates dietary supplement companies on a case-by-case basis as it receives complaints or other information concerning a product's safety or labeling. Preliminary information we obtained from FDA indicates that from fiscal year 1989 to 1992 FDA had taken action against about 290 companies that manufactured or marketed dietary supplements. FDA estimated that, between fiscal years 1988 and 1992, the amount of resources expended to address reported problems or complaints involving dietary supplements ranged from 13 to 57 of the agency's 3,400 full-time-equivalent employees.

Hospital Sterilants: Insufficient FDA Regulation May Pose a Public Health Risk (Report, June 14, 1993, GAO/HRD-93-79).

The Environmental Protection Agency (EPA) and FDA acted correctly in halting the sale of Sporicidin Cold Sterilizing Solution and other products that are disinfectants in December 1991. Although FDA took proper action against Sporicidin International, its overall regulation of other manufacturers of hospital sterilants and disinfectants has been inadequate. In this regard, only a few sterilant and disinfectant manufacturers have registered their products with FDA, and few of the hundreds have been authorized for marketing by FDA, as required by law.

frequently retain some connection with health care delivery, with the consequent opportunity for future violations.

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (Report, July 29, 1993, GAO/HRD-93-94).

The complex eligibility and entitlement provisions of the Department of Veterans Affairs (VA) place more restrictions on the availability of services than do other programs. About two-thirds of veterans eligible for VA care can obtain medical services only to the extent that space and resources are available after other veterans with higher priorities for care are served. Other public and private health care programs essentially guarantee payment for covered services to all eligible participants. Once in the VA system, veterans are generally offered a more extensive array of services, fewer limitations in terms of the duration and number of visits or services covered, and less cost sharing than are available under most public and private health benefit programs.

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, July 27, 1993, GAO/HRD-93-68).

VA could potentially offset a significant portion of its nursing home and domiciliary care costs if it had the same authority states have to operate estate recovery programs under Medicaid. The potential for recovering nursing home and domiciliary costs may be greater for veterans than for Medicaid recipients because (1) home ownership is significantly higher among elderly VA hospital users than among Medicaid nursing home recipients and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients. Oregon's successful Medicaid estate recovery program could serve as a model for a VA program.

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, July 22, 1993, GAO/HRD-93-124).

In 1991, according to American Hospital Association data, about 18 percent of nonprofit hospitals were participating in joint ventures with physicians. The 23 joint ventures we reviewed in depth provided significantly less care to Medicaid and charity patients than their parent hospitals provided. These joint ventures provided evidence that such projects can contribute to excess capacity for medical services in their communities.

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, July 21, 1993, GAO/HRD-93-98).

Separate fees for professional services are not necessary because Medicare's payment amounts for braces and artificial limbs already include a component for the practitioner's professional services. With the assistance of two industry groups, we identified 42 items

result, we do not believe that DOD's comparison was inclusive enough to determine the most efficient method of providing health care to its beneficiaries in Washington and Oregon.

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed for Federal Health Programs (Report, Sept. 17, 1993, GAO/HRD-93-92).

Investigations to date have revealed that federal health programs have been subjected to fraudulent and abusive psychiatric hospital practices, but apparently to a lesser extent than private insurers. Federal programs have many controls in place to guard against unnecessary or poor quality care. However, some control weaknesses exist that render federal programs vulnerable to fraudulent and abusive psychiatric hospital practices, resulting in some unnecessary hospital admissions, excessive lengths of stay, poor quality care, and unauthorized or duplicate payments.

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (Report, Sept. 7, 1993, GAO/HRD-93-121).

To begin addressing the problems faced by pregnant women and children, Illinois is implementing a Medicaid primary care case management program in Chicago called "Healthy Moms, Healthy Kids." Our recent review indicates that plans for this program include management and oversight controls that address prior weaknesses we previously reported in Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (Report, Aug. 27, 1990, GAO/HRD-90-81) and Quality of Care Provided Medicaid Recipients by Chicago-Area HMOs (Testimony, GAO/T-HRD-90-54, Sept. 14, 1990).

Health Care Access: Innovative Programs Using Nonphysicians (Report, Aug. 27, 1993, GAO/HRD-93-128).

This report describes (1) a unique method used by the Indian Health Service (IHS) to deliver emergency and primary care in remote Alaska villages and (2) a Florida county's plans to use aspects of this method to provide health care services in a medically underserved urban setting. The Alaska program trains local residents to provide emergency and primary care services in villages, which are often hundreds of miles away from the nearest physician. The Pinellas County Emergency Medical Services of Florida, whose service area includes medically underserved areas in St. Petersburg, has proposed adapting key aspects of the Alaska program in order to increase access to primary care.

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (Report, Aug. 25, 1993, GAO/HRD-93-129).

A high percentage of policyholders will likely let their policies lapse before they receive any covered services. Unless there is a provision in the policy, these policyholders would not get a return

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
CRI	CHAMPUS Reform Initiative
DC	District of Columbia
DOD	Department of Defense
DOE	Department of Energy
ERISA	Employee Retirement Income Security Act of 1974
EPA	Environmental Protection Agency
FDA	Food and Drug Administration
FTCA	Federal Tort Claims Act
GAO	General Accounting Office
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
IHS	Indian Health Service
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MRI	magnetic resonance imaging
NAIC	National Association of Insurance Commissioners
OSHA	Occupational Safety and Health Administration
PHS	HHS Public Health Service
RBRVS	Medicare Resource-Based Relative Value Scale
SSA	Social Security Administration
USDA	United States Department of Agriculture
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

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